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The Spirit of Achievement

CONVENTIONS provide us an opportunity to share experiences and to expand our own thinking — not to cherish our prejudices. Let us think together, measure things accurately, accept habitually our responsibilities as members of a profession, and go forward in the spirit of achievement. A profession, says one authority, can only be said to exist when there are strong bonds between the practitioners and those bonds can take but one shape — formal association.

During the 14 years between June, 1940, when the Canadian Nurses' Association met last in Alberta, and the present we have witnessed a shortage, the country over, in nursing service. There are more students in our schools of nursing at the present time than ever before in the history of the nursing profession, yet there is never an adequate supply of nurses.

How many of us appreciate the significance of the fact that in June, 1951, 630,290 Canadian children 15-19 years of age were not attending either elementary or high school. Our high schools are educating only 44.5 per cent of the youngsters who graduate from Grade 2 as compared with 70.3 per cent in the United States. Nursing is and must continue to compete with all of the other professions and vocations for recruits. We must bear in mind that, when there is wide-scale recruiting, there may be little, if any, selection. We need many more nurses than we currently have. At the same time we must select wisely if we want our specialty to take its rightful place.

HELEN E. PENHALE

The future of nursing depends upon the vision we have for our own future and upon our ability to guide, encourage, and direct our students toward being complete students. Encouraging students to master a body of knowledge and certain skills is not enough; we have a responsibility to start them on a program of self-education and to give them the fundamental insights and ways of thought that will enable them to draw the maximum profit from their later education in the school of experience.

What are the attributes of a complete student? Each student has the right to be "custom-built" according to her own capabilities. Some of the specifications for a "custom-built" student are:

High standard: Too many of us live at bare subsistence levels intellectually. It is our duty as members of society and of the nursing profession to "lift up a standard for the people."

Discrimination: It is easy to get buried in detail and miss the important things. We must sort out the principles and the details will then fall into their proper place.

Devotion to truth: Indifference to which of two opinions is true is tolerance but indifference to truth itself is a cardinal sin. The scholar will seek the truth at all times.

Discipline: Civilization is self-discipline. Our actions must be dictated by a sense of duty, of fairness and goodwill, of loyalty and good manners, of reverence and modesty.

Decision: This is a priceless habit and fortunately one that can be cultivated. Our custom-built mind sees both sides clearly, considers carefully, then decides.

Action: Decision must be translated into action before it is effective. Are we doing our share to make history or are we just letting things happen? "He who does nothing makes no mistakes" is a motto of complete futility. Its devotee may avoid some little mistakes but makes the big mistake of a wasted life. Good intentions are not enough; there is no substitute for action. Cultivate the habit of transplanting good ideas into action. We may make mistakes but "it is the better part of wisdom not to accept failure ignominiously, but to risk it gloriously."

Initiative and love of adventure: We must read, think, and discuss until we have developed opinions of our own.

Through the years, nursing has come through four cycles — apprenticeship, expansion, regulation and standardization, and critical analysis. The "yesterdays" have brought us to the threshold of achievement; the "tomorrows" will bring fulfillment of our visions and dreams. May those visions behold nurses who can inspire, who can help students to find a new outlook and a broader vision, who can see nursing education as a social development, a part of a comprehensive whole in the building of a better and healthier world with the nurse as a vital factor in the process.

HELEN E. PENHALE, M.A.,
President,
Alberta Association of Registered Nurses

Serum for Arthritis

Rheumatoid arthritis may be greatly relieved by placental blood serum injected regularly for a few weeks. Fifteen women were treated and best responses were noted in the premenopausal age group with disease of recent onset. Material is readily prepared. Immediately after birth, the umbilical cord is clamped and cut, the proximal clamp on the cord is released, and placental blood flows freely into tubes of 60-cc. capacity in amounts averaging 40 cc. The cord is not stripped. Blood is refrigerated overnight. Supernatant serum is pooled in a 500-cc. vacuum container and centrifuged at 2,500 rpm for 45 minutes, then Seitz-filtered and refrigerated. The final product is tested for sterility by culture and serologic test for syphilis. Standard dosage, which may be modified, is 30 cc. injected by vein daily for two weeks, three times weekly for two weeks, twice weekly for three weeks, then weekly for one to three weeks.

— *Davis' Nursing Survey*

Play – A Basic Approach to Pediatric Nursing

HEDLEY G. DIMOCK

A BASIC PRINCIPLE of nursing assumes that the nurse is interested in the patient as a whole person. A hospitalized child, although affected with an illness, is a growing, sensitive and emotional person. Intelligent care includes a complete understanding of the child and only a part of this refers to the illness. It is the patient that is nursed and not the illness.

Today, the trend in nursing is specialization. The same is true of other divisions of the hospital staff. The availability of specialized people has made it more difficult for the nurse to continue the comprehensive tasks of patient treatment. Specialists, often in fields other than nursing, have taken over the direction of many aspects of nursing. What methods are available, then, for the nurse to reorganize her treatment to include the patient as a whole?

An essential feature of pediatric nursing is the provision for the play needs of the child. This article outlines a method of strengthening the basic skills of the nurse so that she is capable of administering to these play needs. The methods, administrative procedures, and coordination between departments illustrated here can, perhaps, be applied to other problem areas. At least, they may result in greater understanding and cooperation between the nurse and a specialized department. The program described is a coordinated one between the departments of nursing instruction and of group guidance at the Children's Memorial Hospital in Montreal.

If play is going to be successfully included as a part of the pediatric nurse's program, it must be approved and supported by the administration of the hospital. Lip service is not enough. The nurse's duties must be revised to include attention to mental health and then she must be given the time and assistance necessary to do a complete job.

Nurses at this hospital have play definitely included as a part of their nursing duties. It includes formal and informal teaching, supervision of nurses as they apply play principles by teaching supervisors and the director of group guidance, and the integration of the nurses with the other parts of the play program. Play, then, is not separated but is stressed as an integral part of complete nursing care.

The majority of the nurses at the Children's Memorial are students on a three-month pediatric affiliation. Eight hours of their formal teaching program is with the Department of Group Guidance. During this time an attempt is made to develop an understanding of children. This includes nurse-child relationships; the child's emotional, social, and educational needs; some behavior analysis; and an orientation to play activities. Principles are drawn from child psychology, group dynamics, and social group work. These principles with some of their basic implications will be outlined.

Children, like ourselves, have emotional needs of love, security, approval and recognition. Under normal conditions these needs are met at home, at school, and in the play groups. The child in the hospital has these sources shut off and must discover new ways of meeting these needs. He is often worried, fearful, and anxious at the time of hospitalization. Once inside the hospital he is faced with the problems of adjusting to the strange faces, new environment, confusing and sometimes rigid routine and, of course, his own illness. These feelings may be expressed in homesickness, regression

Mr. Dimock is director of group guidance, Children's Memorial Hospital, Montreal.

(return to earlier, more baby-like ways), hostility, aggression, withdrawal and other forms of unsocial behavior. The pediatric nurse who is equipped to understand these fears and problems is much more capable of handling the children and hence is a more valuable staff member. The importance of the satisfaction of emotional needs is stressed by pointing out that the "happy," mentally satisfied child:

1. Reacts better to his medical treatment and goes home faster.
2. Is cooperative and more pleasant to nurse.
3. Adjusts to the hospital situations without resorting to problem-type behavior.
4. Is on the road to recovery if his illness is of the type that is closely connected to his mental outlook.

In the last instance the emotional and physical aspects cannot be separated and must be dealt with together. To the child and parent this "mental health" is even more important, for hospitalization can be the most terrifying experience of childhood. Emotional aftermaths may appear immediately in night terrors, fears, obsessions, negativisms, or regressions, or they may not be expressed until later in life.

Group dynamics — the scientific study of groups — develops a sensitivity of leadership, interpersonal relations, group structure, and group movement or progress. An understanding of some of these concepts helps us to:

1. Place a newly admitted child in the proper and most useful group.
2. Make leadership more effective — to recognize and counteract the effects of inadequate leadership.
3. Understand and deal with group actions (riots, scapegoats, contagious ideas or actions, and other phenomenon).
4. Assist groups in adopting attitudes that we think are desirable.
5. Control individual behavior, both positive and negative, through the group.

Social group work points out the functions of play in normal situations and implies the necessity of it in hospital. Play is an important outlet for emotions and energy, both the normal ones and those that might point to a psychiatric condition. An understanding is developed of play activities and techniques that are particularly therapeutic. These centre around forms of free expression — impromptu dramatics, make-believe play, and use of unstructured materials such as sand, clay, finger paint, etc. Social experiences are equally important. They help the child make a happy adjustment to the hospital and to grow and develop, using all his potentialities and the resources of the hospital environment. This can make the social and educational aspects of the hospital experience positive and constructive for the child.

The teaching methods of this program are varied. "Buss" groups, (a large group that is divided into several small groups with each carrying on its own discussion and then reporting back to the whole group), discussions, case presentations, and practical experiences in group play with the children are included. The highlight of the program is the role-playing demonstrations when the nurses put on spontaneous presentations of nurse-patient problems. It is surprising to see how enjoyable and enlightening it can be to pretend you are a patient for a short time. The audience has fun too. They view a somewhat realistic situation and, not being involved in it, are free to laugh at its humor while gaining perspective and insight.

Play is made a part of the nursing program on the administrative level. It is an important part of the teaching program. It is followed up on the wards with supervision from the nursing supervisors, the head nurse and, to some extent, the group guidance staff. Many students have an opportunity to be on play duty. Playing with the children becomes their primary task. Putting classroom material into practice is the weak link in the chain. Nurses who agree with the ideas in theory and want to try them are often unable to do so successfully. Two reasons for this seem worth mentioning:

First, the basic training of nurses stresses physical care almost to the neglect of emotional care. This leaves the nurses wanting to nurse acutely ill patients or babies, for in neither of these is there much concern about emotional needs. The nurse is also led to feel that play and attention to emotional needs come last. They are done only when there is nothing else to do. Consequently, if a nurse is playing with a group of children and there is still physical nursing or charting to be done by other nurses she feels guilty — that she is getting out of something. Perhaps, in the light of this, the basic training curriculum should be re-analyzed to see if "whole patient" nursing is actually being experienced and not just taught as a general principle.

Secondly, play skills and ideas, although to some extent already present, take some time for the nurse to develop in the hospital situation. Three months is not long enough. It has been found that only toward the end of their three-month affiliation are the students secure and relaxed enough, and have developed their own basic skills sufficiently to be really capable in this area. A concern for the patient's recreational needs has to become a part of their basic training program if it is going to be included in whole patient care.

Group guidance staff leads a part of the play program. This accomplishes three things. First, it sets up a demonstration of children playing on the wards for all to observe. Second, it helps to develop some of the appropriate atmosphere for spontaneous play. Chiefly, this means helping the children to get used to playing with each other, using their own initiative for play ideas and relaxing on the hospital wards. It also gives the nurses a chance to mix with playing children. They can do this at their own speed and take over the responsibility gradually as they feel they are able. And, thirdly, it provides special therapeutic activities (often requiring some special equipment or supervision) under professional direction. These activities give the children a chance to demonstrate behavior that is more difficult to control and to play out some of their psychic problems in a controlled situation.

The play program revolves on the principle that the best way to help children grow is to provide them with new and stimulating experiences. Leadership, then, is the important thing and not play equipment. Providing a child with a toy or routine handicraft project is not play in the true sense. These tools are not necessarily constructive and may be merely time consuming. The nurse is the logical leader on a children's ward because she has the primary relationship with the patient. This role needs to be strengthened and not weakened by other people taking over all the leadership for play. Her duty in play is to provide this essential leadership and not games, toys, or play equipment.

The pediatric nurse, then, in broadening her approach to the child patient, combines the physical and mental aspects of the patient. In the early stages of an illness play is made a part of essential physical treatments. As the child begins to feel better, the tempo of play and attention to emotional needs is increased. It is fitted in with the other nursing duties in time definitely set aside for that purpose. To the hospital the broadening of the nurses' duties may mean a revision of these duties to make them more comprehensive and flexible and also providing sufficient time either through organizational changes or staff increases for the nurse to carry out these tasks. Putting these progressive innovations into effect will enable the nurse to give the patient the most rewarding hospital care.

Some of our readers are prompt in letting us know when they move to a new address. Often, however, we find out the hard way — when the envelope and its contents are returned to us undelivered. Please help us to make sure you get your copy regularly by advising us of any *change of address* as soon as possible.

The Psychological Impact of and on the New Arrival

E. McKerlie *and* Laura Einarson

In discussing the impact of the arrival of a baby into a family, we must consider the principal people involved: the parents and the infant.

Child-bearing is increasingly recognized as an emotional, as well as a physical experience. Our modern maternity wards are the outgrowth of the successful attempt to decrease maternal and infant mortality rates. While we have made the process safe, we have interfered with the emotional satisfaction of the family. The young parents of today are more and more demanding that the birth of their babies be a shared experience. Many obstetricians, pediatricians, and nurses have for a long time not been satisfied to use statistics as the sole measure of the success of our care of mothers and babies. In addition they, too, want the arrival of a new baby into a family to be the exciting, rewarding emotional experience that it can and ought to be.

At the first Western Hemisphere Conference of the World Medical Association held at Richmond, Virginia, the conclusion was reached that the trend is definitely towards natural childbirth. While the doctors believed that this could be practised more easily at home, they did not, for many reasons, advocate home deliveries. It was their belief that the advantages of the home atmosphere should be brought to the hospital. Stating that "loneliness is a great ally of fear," Dr. J. N. Eastman, obstetrician in chief at Johns Hopkins, said that a woman in labor should not be left alone in hospital. "Her husband is her best companion during labor but if not her husband then certainly a close relative or friend." He pointed out that this is an important factor lacking in obstetrical care in this country but that hospitals are now trying to make up for it. "Many women approach childbirth in dread of the ordeal," Dr. Eastman declared. "When a mother puts her complete confidence in the doctor of her choice, and feels that he is competent to handle any emergency, that in itself is a potent basic analgesic."

More and more the professions and the parents are realizing the importance of the part adequate maternity care plays in establishing sound family relationships. All of us begin our lives as members of a family unit. The family is the first social influence to which the child is exposed. The period that the mother and baby are in hospital is the very beginning of the establishment of emotional rapport between the infant and his parents. If this relationship is to be happy and secure, preparation and planning should begin long before the baby is born.

Emotional Problems

Let us consider some of the common emotional problems of prospective parents. Both the mother and the father are likely to have very mixed feelings about this event. Fatherhood is an increasingly important role. A man who is psychologically ready to play his part can give his wife the very desirable peace of mind that should be hers during pregnancy. The professions are becoming more and more aware of their responsibility to help him prepare for this and are beginning to include him in the instruction given his wife.

Most women, whether they are aware of it or not, do have some apprehension regarding childbirth. Although usually the first feelings of a woman when she finds out she is pregnant are excitement and anticipation, there is an underlying instinctive fear of the un-

Miss McKerlie is assistant director of the Winnipeg branch of the Victorian Order of Nurses where Miss Einarson was formerly a supervisor.

known. Strangely enough, even women who have had several children often have no idea of what happens. They have only a memory of confusion and pain. Added to this, there is sometimes a crushing feeling of responsibility for the feeding, clothing, and general welfare of this child. Many of them have heard and read so much about "scientific" methods of child rearing, that they have come to mistrust their own instincts and feelings.

It is a great mistake to assume that all women welcome pregnancy. To a few it is very unwelcome. The more fortunate members of this group are able to express their negative feelings fairly freely to a sympathetic listener and thus, having rid themselves of their burden, proceed to a healthier attitude. Others, afraid of disapproval, bottle up their negativism, thus making for greater mental conflict and distress. We in the "helping" profession must be wary of intruding our own feelings regarding childbearing into our relationships with our patients. We must be ready to listen to them. The reticent woman may be unable to voice her fears and apprehensions, so that her first timid questions must be gently and tactfully dealt with.

Many women, too, are overly concerned with their own physical well-being during pregnancy. If the husband has a not uncommon "guilt" feeling about having caused his wife to conceive, he may react by showing an exaggerated concern, thus encouraging his wife towards invalidism. An unimaginative couple may plod along without knowledge or concern. Those who have been given only vague impressions of the route may anticipate danger at every turn. The well informed couple will recognize the signposts along the way and will travel it with interest, excitement, and anticipation. Ideally, all people should be taught the truth about reproduction in early childhood. Lacking this, prospective parents should be provided with a factual picture of what is happening now.

Being Together

When the parents have anticipated and prepared for the coming of this baby, is it fair to separate them at the culmination of their months of waiting? Parents who have experienced being together at the actual birth report that this was the supreme moment of their lives. A baby born under such circumstances has a solid background of being wanted and accepted by both of his parents.

If, following this "togetherness" at birth, the set-up at the hospital permits rooming-in, both parents have the opportunity to get to know and become identified with their baby before they take him home. The pediatrician and hospital nurse have a unique opportunity here to observe the parents with their baby and to help them adapt to his needs and demands. This is a perfect teaching opportunity.

The personality of the parents, their social and cultural backgrounds and traditions, their life experiences — all these must be taken into consideration in teaching parents about the care of their infant. The simplicity of the job should receive greater emphasis. Every effort should be made to avoid being either too technical or too authoritative.

Baby's Care

From the very beginning, the parents should be given some responsibility for their baby. This is the time when they are building up confidence in their own ability to look after their child. They should be encouraged to rely on their own natural impulses and not depend too much on the nurse or the doctor, although help and advice should be available. At first the nurse and doctor interpret the baby to the parents. Most parents, after a few weeks, are well qualified to interpret their own baby to the professionals, since among the millions of babies this one is unique — there is no other just like him.

It is a well recognized fact that the mother experiences an emotional letdown when she first arrives home from hospital with her new baby. This probably results from the emotional strain of nine months of pregnancy, plus the physical aspects of renewing and repairing her body tissues. To in-

sist that she take on at once the full responsibility for her baby may only undermine the self-confidence that should have been built up in hospital. We must have much greater continuity of service between hospital and homes. Nurses who have had experience visiting these new mothers in their homes know how badly they need this continued help. The seemingly self-assured mother in hospital often finds the adjustment to caring for her baby in the home just as difficult as her less self-reliant ward mate. She needs to be assured again and again that the job is simple. To quote a much relied upon authority on child care, "You know more than you think you do." (Dr. Benjamin Spock).

The Demands of Infancy

Every baby is unique. From birth, he has a personality that can be affected by what he experiences. Being human he has the basic needs of all human beings, for food, air, warmth, clothing, shelter, to be loved, and to love in return. In the beginning the infant learns to accept love as his demands are met. In this way he gradually learns to give love back. This ability to give and receive love is fundamental to his happiness in later life.

What are these demands of infancy that must be met? Having come from the warm security of his mother's body, he has to learn to accept the many discomforts of his new environment — the sensations of hunger, sucking, digestion, elimination, even breathing. He is unused to having his body handled. He has also to accept clothing which sometimes binds him and interferes with moving and stretching. It is generally accepted that at birth he has only two fears — of falling and of loud, jarring noise. The latter does not mean that conversation has to be whispered because he is sleeping. He has to learn to live with people. Those caring for a baby must remember that he is completely dependent and that he has only one way of communicating his needs. He cries. He may want food, he may want to be turned because he is tired of lying in one position, or he may only want the assurance that someone is there to answer his cries, to cuddle him. Loving and fondling by his parents cannot spoil him.

Parents need to develop a philosophy of feeding. Whether breast or bottle fed, a baby needs more than food. He needs the warm, personal closeness of a mother who enjoys this interlude and is willing to give it her relaxed attention. This should be one of the family's social times together: the baby should be getting satisfaction and security as well as appeasement of his hunger. Many a mother damages the emotional rapport that should exist between herself and her baby at feeding time because she is tense and anxious that the baby is not "taking enough" or because he "spits up." When she realizes that some babies are air-gulpers and need "bubbling" during feeding, or that at other times a baby just plain eats too much and therefore has some overflow, she is much relieved.

The emotional tie between mother and infant is so close that an overly anxious mother makes a fretful baby and later a maladjusted child. This shows in early babyhood in constipation, vomiting, refusing feedings and, perhaps, failure to gain weight as quickly as is desirable. Behind almost every feeding problem there is a mother who, had she been able to seek out and accept help earlier, might have had less trouble.

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Many people are lonely because they build walls instead of bridges around themselves.

Asphyxia Neonatorum and Resuscitation Methods

HELEN GRACEY *and* NORMA MORASUTTI

ASPHYXIA NEONATORUM is respiratory failure of the newborn, in contrast to the absence of breathing (asphyxia) in the adult. It is characterized by the continuation of the heart beat, long after cessation of respiratory movements.

The cry of the newborn is eagerly anticipated as a sign of his ability to breathe. The exchange of oxygen and carbon dioxide in the fetus is made by way of the placenta. At birth that exchange is cut off and the infant must breathe in order to live. If respiration is not established a state of anoxia results because the body cannot obtain oxygen or rid itself of accumulated carbon dioxide. Barcraft says:

> Nervous tissue is more sensitive to the deprivation of oxygen than any other tissue. Anoxemia of mild degree impairs its coordination. Even a short duration of asphyxia abolishes its functional activity. Complete anoxemia maintained even for ten minutes, or less acute, for a longer time, may lead to irreparable damage to the nervous system.

After delivery two degrees of asphyxia may occur — livida and pallida, depending on the degree of anoxemia.

In *asphyxia livida* the infant is dark blue; his face becomes swollen and congested. The skin around the nose and mouth may be slightly pale, the lips are deep blue and the body is rigid. Heart and cord pulsate slowly and strongly. An occasional gasp is accompanied by a gurgling sound resulting from mucus in the mouth and bronchi. Mild cases respond quickly to treatment.

In *asphyxia pallida* the infant is pale and waxy, the body is limp, and no respiratory movements are noted. The only evidence of life is a weak, slow or extremely rapid heart beat. The lungs are not fully inflated; areas of atelectasis exist, which offer great resistance to the flow of blood. The anoxemia affects the nerve centres and the infant becomes comatose.

The cyanosis may arise as a result of conditions operative before birth. There may have been interference with the infant's oxygen supply owing to:

1. Prolapse of the cord with compression of it between the head and the pelvic brim.
2. Coiling of the cord about the infant's neck.
3. Premature separation of the placenta.
4. Intense uterine contractions compressing the placenta. In some instances there is a developmental defect of the brain and the nerve centres which regulate respiration.

Injury to the brain at birth usually causes respiratory difficulties. This is apt to occur in prematurely born infants but it is also seen in infants born at term where the delivery has been difficult. Cyanosis may occur in prematurely born infants without any cerebral injury, owing to imperfect development of the respiratory mechanisms. In these infants the lungs may fail to expand properly for several days after birth (atelectasis).

Difficulty in initiating adequate respiration may result from analgesic or anesthetic drugs given to the mother. Another cause of blueness in newborn infants is a congenital defect of the heart.

Prevention: The skilful obstetrician takes judicious care in the use of analgesics, oxytocics and inhalation anesthetics, and by avoiding as much as possible the more difficult types of operative delivery. By listening regularly to the fetal heart sounds, he may

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Miss Gracey is caseroom and obstetrical supervisor at the Misericordia General Hospital, Winnipeg, while Miss Morasutti is also a caseroom supervisor at the same institution.

detect early signs of trouble and it may be possible for him to deliver the infant before permanent damage has been done.

Management before birth: If the course of labor is following normal channels, intervention by operative delivery or Caesarean section would be used only in an emergency. Delivery should always be effected with the regard for both the infant and the mother.

Management after birth: Resuscitation of apneic newborn infants should be started immediately after birth instead of waiting for the onset of spontaneous respiration. No time is to be wasted on inefficient measures. In mild asphyxia the simplest remedies are usually successful.

Governing principles and treatment:

1. Proper position — the infant should be suspended with the head down to facilitate drainage of mucus and other secretions from the throat and mouth.

2. Body temperature must be maintained with warm blankets or a preheated crib.

3. Respiratory passages must be cleared — gentle suction may be necessary.

4. Supplying air or oxygen to the lungs is essential. The blood of the infant must be supplied with oxygen and the circulation must be started again. Methods of supplying air and oxygen include:

(a) Mouth to mouth insufflation.

(b) Gentle compression and relaxation of the thorax.

(c) Blowing air or oxygen gently through an inserted tracheal catheter. Artificial respiration is kept up until the infant recovers or its condition shows that further effort is useless (usually one hour).

(d) Hospital respirators — Kreiselman, Flagg, Drinkers, Bloxsom air and oxygen pressure lock.

A relatively new apparatus, the Bloxsom air and oxygen pressure lock, developed by Dr. Allen Bloxsom of Houston, Texas, has been in use at the Misericordia General Hospital for some time. The principle on which the oxygen air pressure lock operates —

MRS. G. H. EVOY, *president of Misericordia General Hospital Auxiliary, is shown with* SISTER SUPERIOR ST. BERTHA, *and* MISS GRACEY *after presenting the hospital with a new baby resuscitator.*

diffusion oxygenation — is described as follows:

> Oxygen under positive pressure, cycled between one and three pounds at one-minute intervals, diffuses through the epithelium of the smaller bronchioles and other epithelial surfaces to reach the capillary blood. The theory is that oxygenation thus produced, even in the presence of complete apnea, will sustain life for sufficient periods of time to allow the spontaneous development of respiratory activity, if it is ever going to develop.

Benefits of this machine, as stated by the John Bunn Corporation, are noted. It provides:

1. High oxygen concentrations.
2. Oxygen under positive pressure with or without cycling.
3. Humidity.
4. Controlled temperatures.
5. Favorable conditions for the diffusion and use of oxygen by the premature infant.
6. It requires no handling of the infant on the part of the physician or nurse with possible trauma.
7. It acclimates the infant to neonatal conditions.

From our experience with oxygen air pressure lock, we feel that the above summary of benefits is most accurate. We especially like the fact that it provides controlled temperature and requires no handling of the infant by the physician or nurse.

After-care and observation: Since the lungs expand slowly, with the occasional secondary asphyxia developing in a few minutes to a few hours, all asphyxiated and premature infants and those delivered by severe operative procedures should remain under frequent and careful observation for several days. This is the responsibility of the nurse. She must be familiar with the appearance of a normal newborn and be able to detect the slightest change in his appearance. It is thus essential that the nurse consistently improve her power of observation and her ability to describe what she sees in an accurate concise manner. Such a nurse will not only have in readiness all equipment required but she must have a thorough understanding of the physician's orders as well. Certainly resuscitation of the newborn presents a challenge to the nursing profession.

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A record 411,000 births were registered in provincial vital statistics offices during the 12 months of 1953, 4 per cent higher than the previous 1952 record. When all 1953 births have been registered and tabulated, it is estimated that an all-time Canadian record of at least 415,000 births will have occurred in 1953 — a continuous annual rise from 359,000 in 1948. The 1953 birth rate (per 1,000 population) is estimated at 28.1 as compared with 27.9 in 1952, 27.1 in 1950, and a record 28.8 in 1947. More births were registered than in the previous year in all provinces except two, with Alberta, Nova Scotia, British Columbia, and Ontario showing the highest increases.

A total of 133,366 marriages were registered during 1953, 4.8 per cent higher than 1952, with increases over the previous year in all but two provinces. Provisional estimate of total 1953 marriages is 134,000 as compared with 128,308 in 1952, accounting for a rate of 9.1 per 1,000 population, and increase from 8.9 in 1952.

Although deaths registered during 1953 increased 2.3 per cent over the previous year, it is estimated that total 1953 deaths will amount to 129,000 with the same rate of 8.7 (per 1,000 population) as in 1952.

—Dominion Bureau of Statistics

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There's not much point in running away from things, because at the end of the journey you usually meet yourself.

Nutritional Disturbance in Infancy

DAVID GREWAR, M.D. *and* GRACE LINNEY

CHRONIC NUTRITIONAL DISTURBANCE is a common occurrence in infancy for which there are many causes. The most commonly met with are represented in the following list:

1. *Inadequate intake of food from*: (a) Poverty, ignorance or special cult; (b) disordered appetite, either organically or psychologically conditioned.

2. *Congenital anomalies*: Hiatus hernia with esophageal reflux of food and sometimes associated esophagitis, cardiospasm, pyloric stenosis, megacolon, chronic intussusception, hydronephrosis, congenital renal hypoplasia, congenital malformation of the heart.

3. *Chronic infections*: Tuberculosis, syphilis, malaria, post-basal meningitis, chronic respiratory infections (e.g., bronchiectasis), infections of the kidney, chronic dysentery (both bacillary and amebic forms), cirrhosis of the liver.

4. *Metabolic disturbances*: Persistent renal acidosis, idiopathic hypercalcemia, endocrine dysfunction (e.g., diabetes), adrenogenital syndrome of infants (a form of adrenal insufficiency in children).

5. *Malignant disease*: Leukemia and other forms of reticulosis, neuroblastoma, nephroblastoma (Wilms's tumor of the kidney), cerebral tumor.

6. *Chronic steatorrhea of childhood*: True celiac disease, cystic fibrosis of the pancreas (mucoviscidosis), atresia of the bile ducts, obstruction of the lacteals from various causes.

STEATORRHEA

"Celiac syndrome," or chronic steatorrhea of childhood, has probably come in for more abuse as a diagnostic term than any other when some nutritional disorder of childhood presents itself. Some relevant discussion on the basis of the newer conceptions of fat metabolism would, therefore, appear to be pertinent.

Steatorrhea simply means the passage of excessive amounts of fat in the stool causing them to be exceedingly bulky, pale and offensive. As a result of the unavailability of this important food to the body, wasting and failure to gain ensues.

Normally, 85-90 per cent of the fat eaten is absorbed and either used by the body as a source of energy or stored. The absorption of less than 85 per cent results in steatorrhea, the various causes of which will now be studied. The process of digestion and absorption of fat requires the presence of: bile from the liver; lipase from the pancreas; a normally functioning, absorptive lining of the bowel.

1. *Bile*, which has an emulsifying effect on the fat, may be absent in any condition which prevents the passage of bile from the liver. The most common cause of this in infancy is atresia of the bile ducts. Infants thus affected, however, seldom live beyond the first year and do not, therefore, concern us greatly so far as chronic nutritional failure is concerned.

A few infants, instead of having an anatomical obstruction, have thickened bile precipitated in the bile ducts. This obstructs the ducts but only temporarily and such children soon free themselves of jaundice and thrive normally. This again is not altogether in the category of a chronic nutritional disorder.

2. The *absence of lipase*, the fat-splitting enzyme secreted by the pancreas, is in children almost always due to cystic fibrosis of the pancreas. This is now recognized as a generalized disease, involving all the mucous secreting glands in the body hence some have suggested the term "mucoviscidosis" in preference to that of cystic fibrosis of the pancreas which draws attention only to one of the sites of the disease.

It is a genetically determined disease and affects one out of four of the children born of parents who carry the

Miss Linney is nursing arts instructor at the Children's Hospital, Winnipeg. Dr. Grewar, who assisted in the preparation of the medical aspects, is resident at the Children's Hospital.

recessive gene but do not themselves exhibit any of the signs of the disease.

3. A *normally functioning lining of the bowel* is an obvious prerequisite to the absorption of fat as well as other food elements.

There is a subtle interrelationship, as yet not quite understood, between absorption of fat and carbohydrate. A disturbance in this interaction causes *true celiac disease* in childhood and the so-called malabsorption syndrome of adults (non-tropical sprue). The child with celiac disease is now known, not infrequently, to become the adult with non-tropical sprue. Professor Davidson in Edinburgh has shown this natural history of celiac disease in 30 per cent of the cases of malabsorption syndrome in adults.

Once through the intestinal lining, the fat is distributed via the lacteals or the portal blood stream. Occasionally, the lacteal pathway can be blocked — e.g., by intestinal tuberculosis — and thus cause impaired absorption and a celiac-like picture.

The two major causes of steatorrhea, namely, cystic fibrosis of the pancreas and true celiac disease, have only comparatively recently been differentiated. The treatment of each of these conditions is now on a rational basis so the ability to recognize the clinical features and understand the diagnostic measures is of more than academic interest.

True Celiac Disease

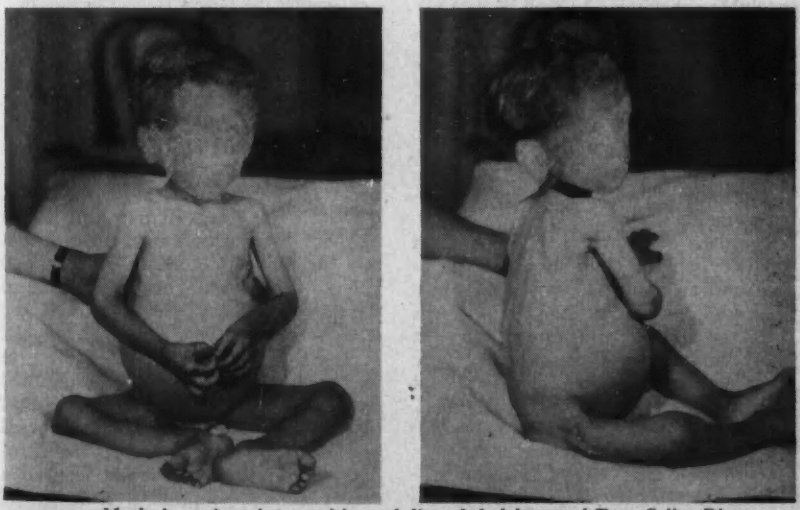
The original clinical description by Samuel Gee (1888) is unsurpassed:

> Celiac disease is a kind of chronic indigestion which is met with in persons of all ages, yet is especially apt to affect children between one and five years old. Signs of the disease are yielded by the feces: being loose, not formed, but not watery; more bulky than the food taken would seem to account for; pale in color, as if void of bile; yeasty, frothy, an appearance due to fermentation; stinking, stench often very great.
>
> The onset is usually gradual so that its time is hard to fix; the patient wastes more in the limbs than in the face; cachexia is a constant symptom; the belly is soft, doughy, inelastic, sometimes distended and rather tight.

Clinical Features

Anorexia: This is often the initial symptom. It becomes extreme until the child will take very little food.

Failure to gain or loss of weight: At first, failure to gain is the only evidence of diminished intestinal absorption, but in a short time wasting becomes evident, particularly noticeable



Marked wasting of extremities and distended abdomen of True Celiac Disease.

in the buttocks, axillary folds and groins (see photograph).

Abdominal distention: This is a conspicuous feature, appearing early in the disease and disappearing only slowly during recovery.

Behavior changes: All normal spontaneity and happiness disappears and these children show no response to efforts at entertainment or show of affection. Irritability, crying and temper are prominent and the demands of the child become very exacting. One is often reminded of these little patients in terms of "When she was good, she was very very good, but when she was bad she was horrid."

Vitamin and mineral deficiencies: Vitamins A and D, being fat-soluble, are poorly absorbed by the child with celiac disease. The inadequate absorption of vitamin A can lead to a devitalized state of epithelialization. Where the respiratory surfaces are concerned, this leads to a proneness to respiratory infection. If there is insufficient vitamin D absorbed, rickets will occur but this condition may remain occult if there is failure in growth generally, for rickets only becomes apparent in a growing bone. Furthermore, calcium deprivation may occur because the calcium combines with the excess of fatty acids in the bowel and forms an insoluble substance. As well as calcium deficiency, however, there is often evidence of another mineral, iron, being poorly absorbed with resulting hypochromic anemia. The exact mechanism of iron absorption is not understood. Very occasionally, another blood-forming element, vitamin B_{12}, is not available to the celiac patient and macrocytic anemia occurs.

Diagnostic measures: There is a tendency when a child shows failure to gain and an abnormal stool to make a diagnosis of celiac disease. This seems both unscientific and unnecessary as many authorities indicate that there are diagnostic measures which permit of a more or less definitive diagnosis.

Fat balance estimation: This is simply a comparison of the amount of fat ingested with that excreted in the stool. It is a difficult test to carry out, as it requires an exact estimation of the amount of fat in the food that is eaten and a total collection of the stools (which must be urine-free) over a period of not less than three days. A marker such as charcoal or scarlet red is given with the food and is used to begin and end the test. The stool is then dried and examined for fat content, the result being compared with the fat intake. If less than 85 per cent of the fat taken into the body is absorbed, then steatorrhea is confirmed. The many difficulties which arise in carrying out such a test in infancy are obvious. This test does not, however, distinguish the steatorrhea of true celiac disease from that of cystic fibrosis of the pancreas.

Vitamin A absorption curve: This is a simpler test. The child is given a massive dose of vitamin A by mouth. In normal individuals a considerable rise in the blood level of vitamin A takes place five to seven hours after the oral administration. Where there is steatorrhea, the vitamin A is not adequately absorbed and there is no rise in the blood vitamin A level.

Glucose tolerance test: In celiac disease, the blood sugar curve never rises more than 40 mg. % because, as well as poor fat absorption, there is poor carbohydrate absorption by the disordered bowel. This is called a flat curve and is confirmatory evidence in a child presenting the typical clinical picture of celiac disease. It also distinguishes celiac disease from cystic fibrosis of the pancreas as in this condition there is a normal glucose curve.

Treatment: Although the cause of true celiac disease is still undetermined, it is known that carbohydrates have an effect on fat metabolism in the body.

During the war, British and Dutch workers drew attention to the fact that the incidence of celiac disease had fallen and that this could be related to the fact that wheat flour, because of the war, was much less readily available. It was then shown that when the gluten portion of wheat was eliminated from the diet of a child with celiac disease, the steatorrhea disappeared and nutrition improved. Its re-introduction, on the other hand, caused a recurrence of symptoms.

In Holland, Dicke and van de

Kamer observed that both wheat and rye flour exert a deleterious effect upon fat absorption in children with celiac disease. They found, however, that when the protein-component gluten was removed the remainder, consisting of wheat starch, was well tolerated.

The object, then, is a diet from which gluten is completely excluded but which in other respects is normal. There may have to be an early phase in which fat is reduced and starchy foods entirely withheld. Several weeks of careful, experienced, and persuasive nursing may be required before a child will accept a diet free of gluten. As soon as it has been accepted and is taken satisfactorily, the caloric intake can be steadily increased until weight begins to rise. A dietary schedule as recently suggested by Dr. Wilfrid Sheldon, of Great Ormond Street Hospital, London, is as follows:

For the severely ill child — offer only four foods: skimmed milk, Prosol*, glucose and banana purée. If the stools remain watery, "Arabon" may be used to help consolidate them.

The first additions to the diet are: minced chicken, egg custard, and soda biscuits with butter and honey. Sieved starch-free vegetables such as cabbage, cauliflower, tomatoes, stewed fruits, and cheese may be added gradually.

The final step is to add starch but strictly to avoid any gluten-containing foods. A gluten-free wheat flour is sold which may be used in making puddings, breads and biscuits. (Baking with this type of flour takes some practice.) Potato and rice flour may also be used.

The child is now on a full diet from which only gluten is absent. Vitamin concentrates A, B, C, and D are given to prevent development of deficiency complications which were at one time a common feature of celiac disease. In the event of anemia of the hypochromic type, a simple iron preparation will be prescribed.

Nursing Care

The care of children with celiac disease is symptomatic, falling roughly into categories concerning the diet, prevention of infection, and management of behavior.

Haas and Haas report some of the peculiarities noted in the appetite of these children. Some demand food but then refuse it as soon as it is brought into sight; others will eat only from a special plate using one special spoon; others refuse food unless it is prepared by one particular person. Again, others will show a preference for one specific food such as milk, potato or ham and will consume large quantities of it.

The need for patient, gentle persuasion is obvious. It is undesirable to force the child to eat. Garrod suggests food should be given in small amounts that will be completely consumed during the meal and will allow hunger to appear just before the next feeding.

If banana is to be used in the diet, only the ripe fruit should be used. Haas describes the fully ripe banana as "one with no trace of green at the tips, the skin well speckled with brown, and the edible portion soft enough to mash easily." If this is not available, banana powder may be substituted.

The strictness of the diet cannot be overemphasized. Faithful observance requires intelligence on the part of the nurse or the mother caring for the child with celiac disease.

If a food is not well tolerated by the body, there is immediate evidence in the frequency and consistency of the stools which become bulkier and more offensive. An accurate record of the number, size, color, consistency and odor will be a helpful indication of the progress in dietary treatment.

Frequent change of position is indicated during the severe stage of the disease since the child tends to lie in one position for long periods. Due to malabsorption of vitamins, the child is prone to respiratory infections, thus necessitating changed positions to avoid pneumonia.

Cleanliness of the skin is necessary not only because of the poor nutritional state of the body but also because of the fecal odor that tends to cling to the skin and can be reduced only by frequent cleansing.

*Prosol is a dried skimmed milk with added proteins (Trufood Limited).

Irritability, fussiness, crying and temper are prominent symptoms. This fact must be borne in mind if we are to successfully manage children with this disease. What we would consider as spoiling in a healthy child is actually necessary in a child with celiac disease. Patience is indeed a virtue. It should be realized, however, that a show of affection often brings about increased irritability. Patience tempered with tact, gentle persuasion, and kindness will produce satisfactory results in most instances.

Fatigue should be avoided and play therapy regulated sufficiently to provide for the emotional needs of the child without causing him any exertion.

The course of the disease is a long one often extending into months or even years, therefore preparation of the mother in the care of the child should begin early. Observation of the management in hospital is very helpful and should be arranged, if at all possible, so that the mother has adequate opportunity to learn under the supervision of the nursing staff.

The most important point to remember in the care of these children is that no two can be treated alike. In this disease more than in any other, all aspects of the care must be adjusted to the needs of the individual child.

Fibrocystic Disease of the Pancreas

The underlying cause of this disease is a developmental defect of the pancreas, part of a widespread mucous-secreting disorder. The glands secrete a viscous type of mucus which occludes the gland ducts and leads to cystic formation. The main brunt of the disease falls upon the pancreas and the lungs; in the case of the pancreas, leading to failure of pancreatic enzyme secretion; in the case of the lungs, causing a cystic process with secondary infective complications which ultimately lead to a state of widespread bronchiectasis.

Steatorrhea follows from failure of pancreatic enzyme production and a clinical picture ensues, similar in many respects to that of celiac disease, with bulky, offensive, pale stools, failure to thrive and wasting.

In some cases, however, the respiratory tract is predominantly involved and some of the infants with cystic fibrosis of the pancreas die of pulmonary infection even before there has been sufficient time for them to show well marked signs of nutritional failure.

Clinical Features

The symptoms may be grouped as: gastrointestinal — associated with the pancreatic lesions; nutritional — resulting from impaired absorption of food and effects of the chronic infection; and, respiratory — associated with chronic infection in the lungs.

Gastrointestinal: The almost complete lack of trypsin, lipase, and amylase causes a marked impairment in the digestion of food. At first the stools may be loose, green, and frequent but as time passes, they usually become pale, bulky, mushy, and offensive. The stool is held, by some, to have an odor altogether peculiar to the disease, it being both putrid and faintly sweet, with a tendency for the odor to persist and cling to the body.

Nutritional: The appetite is usually ravenous. It would seem that the child is endeavoring to compensate for the poor absorption by increasing the intake of food. Distention of the abdomen is not striking in the early phase of the disease but after several months becomes quite marked. Wasting becomes quite severe and is evident early in the disease despite the good appetite.

Respiratory: A history of pulmonary infections, recurrently since birth or during the first few months, is usually present in infants with fibrocystic disease.

Diagnostic Measures

Trypsin estimation: The crucial test for fibrosis of the pancreas is the determination of pancreatic enzymes in the duodenum. Trypsin is the most revealing analysis and is either absent or very markedly reduced in this disease.

Blood amino acid tolerance test: In fibrocystic disease, the absence of trypsin is responsible for the inability of the body to break down casein into amino acids. In this test, casein or gelatin is

given by mouth. Two or three hours after the oral administration, a blood test is taken to determine the blood level of amino acids. Normally there is a definite rise. In the child with fibrocystic disease, little or no rise is evident.

The presence of fibrocystic disease is suggested by the characteristic history plus the clinical symptoms and confirmed by the above tests. One factor, often of value in making a diagnosis, is the history of a death in a sibling from gastroenteritis or bronchopneumonia.

Treatment

When pancreatic enzymes are lacking, the amount of food absorbed increases to some extent with increased intake. Thus an abundance of food is allowed — enough to satisfy the appetite despite the appearance of the stools. Nutritional improvement is more likely to occur if predigested food (e.g., nutramigen) is given since this does not require further digestion. Pancreatin (a pancreatic enzyme) may also be used to help take the place of the patient's natural pancreatic enzymes and thus aid digestion.

Treatment of the pulmonary lesion has been unsuccessful in so far as cure is concerned, but much can be done to promote well-being and prolong life by the use of antibiotics. The organism usually present in the pulmonary infection is the *Staphylococcus aureus*.

Nursing Care

The care is very similar to that given in celiac disease. One aspect of it, however, deserves special mention. The prognosis of this disease is so adversely affected by pulmonary infection that every attempt must be made to prevent its occurrence. Hygienic surroundings and avoidance of droplet infection are the most important measures in this respect and warrant extra attention when determining the plan of cure.

The appetite should be appeased, frequent feedings often being indicated. The nurse should spend as much time with these children as possible. Most of them are hospitalized a great deal of the time due to recurrent respiratory infections and, therefore, miss the love which is given in the home during the early months of life.

Once again, it should be stressed that individualized care is a *must*. The infant with fibrocystic disease will need more actual nursing care than the child with celiac disease, the amount varying with the severity of each.

In conclusion, it will be appreciated now that in many respects fibrocystic disease of the pancreas and true celiac disease have many factors in common although the outlook and management is very different. In order to assist in the differential diagnosis, a list of the similarities and distinguishing features is given.

Differences	*Fibrosis of the Pancreas*	*Celiac Disease*
Familial incidence	Common	Rare
Appetite	Good	Poor
Pulmonary infection	Present	Absent
Pancreatic enzymes	Absent	Normal
Amino acid curve	Abnormal	Normal
Glucose tolerance curve	Normal	Always flat
Similarities		
Wasting	Extreme	Extreme
Abdominal distention	Marked	Marked
Fat absorption	Decreased	Decreased

Gamma globulin has been used in prophylaxis against infectious hepatitis (epidemic *viral)* since 1945. From wide experience in both civilian and military communities and institutions, it appears that although gamma globulin does not protect when given later in the incubation period (five to six days before onset of symptoms), it does confer a passive immunity lasting perhaps from six to eight months. Doses as small as 0.01 cc. per pound are effective.

—*Physician's Bulletin*

Acute Intussusception in Infancy

1. Diagnosis

HARRY MEDOVY, M.D.

RUSSEL W. WAS A HEALTHY, four-month baby boy who weighed 16 lb. 2 oz. on October 6, 1953. He was breast fed and except for an inflammation involving one of the glands in his neck had been quite normal, until the morning of October 29. He had just started to nurse when he seemed to have a severe cramp, stopped nursing, cried out and vomited for the first time in his life. According to his mother's description he then went "dead white" and looked as if he had fainted. His mother thought this was a natural result of his having vomited. He was not interested in feeding any more and periodically would draw up his legs, scream as if in pain and then relax into a sort of listless, dull state, more or less uninterested in his surroundings and obviously unhappy.

When he did not show improvement by mid-afternoon his mother became worried. At about 2:00 p.m. Russel had a bowel movement that had some "red" in it. His mother blamed this unusual color on strained beets he had had the day before. At 4:30 p.m. the mother finally became disturbed and telephoned the doctor who asked to have the baby brought up to his office immediately. He arrived at 5:00 p.m., looking pale and uncomfortable. When the examining hand was placed on the abdomen a lump the size of a small grapefruit could be felt in the centre of the abdomen above the umbilicus. It could be moved about easily although it caused obvious discomfort when this was done. Periodically he would have a severe cramp which caused him to draw up his legs and whimper.

When the examining finger was inserted into the rectum there was no stool to be felt and no masses. As soon as the finger was withdrawn a trickle of dark red blood and mucus came out of the anal opening.

With a history of sudden onset, acute abdominal pain, vomiting, collapse, blood in the stool, and the finding of an abdominal mass, the diagnosis of an intussusception was made. The diagnosis was confirmed a few minutes later by means of a barium enema which showed the characteristic findings of an intussusception in the region where the mass had been felt.

The term intussusception comes from two Latin words meaning "to receive within." It refers to the process by which one portion of the intestine slips into another portion immediately below and is "received" by it like a finger into a glove. It is one of the commonest and most important surgical emergencies in infancy. The sudden telescoping of a portion of bowel into a more distal portion gives rise to the acute pain and vomiting that is so characteristic of the condition. The infant's reaction to this abrupt occurrence is to cry out with pain and draw up its legs. Vomiting usually occurs and the associated shock is responsible for the picture of a pale, listless, unresponsive infant who seems to react only to the recurrent spasms of abdominal pain. The telescoping of the bowel gives rise to extreme congestion of the blood vessels which are dragged along with the bowel and bleeding occurs. This trickles down the bowel, mixes with the fecal contents and appears in the characteristic stool. The mass that the doctor can feel in nearly every case is the actual telescoped bowel.

Not all cases are typical. In some, the infant seems quite well between attacks of severe pain which may last for only a minute or two. He may actually smile and play and give one a false sense of being well when all the time he is the victim of an acute obstruction

Dr. Medovy is associate professor of pediatrics at the University of Manitoba.

that must be recognized and corrected within a matter of a few hours if he is to survive. Therefore, even if the baby seems quite well at the moment of examination, the story of an acute onset of severe cramps, vomiting, and shock makes it necessary to exclude the diagnosis of intussusception in every case.

Blood is not always found in the stool and its presence is not essential for the diagnosis. The characteristic sequence of events, coming on suddenly in a baby previously well, is the most important point in arriving at a diagnosis. No mother who presents such a story should be "reassured" or told to wait overnight before the baby is given a careful medical examination to verify or exclude intussusception.

Treatment must be promptly and thoroughly carried out. In some instances reduction of the intussusception is possible by means of a barium enema given by a radiologist experienced in the handling of infants. It is important when this is done that absolute assurance be given by the radiologist that reduction has been accomplished. Failing this assurance, prompt surgery is necessary. The mortality rate is negligible if diagnosis and treatment can be carried out within 24 hours of the onset. After 24 hours the mortality rate rises rapidly so that after 72 hours the infant's chances of survival are reduced to 50 per cent or even less.

Russel W. was a lucky boy. During the process of confirming the diagnosis by the barium enema, the reduction of the intussusception by the method described by Dr. Childe was completely successful. Russel has remained perfectly well ever since.

2. The Role of the Radiologist

ARTHUR E. CHILDE, M.D.

THE PRESENCE OR ABSENCE of an intussusception can be very accurately diagnosed by the administration of a barium enema. Nearly always, by the time the patient comes under observation, the head of the intussusception has reached the large bowel. If the sigmoid should be long and redundant, a small defect in the region of the ileocecal valve may be difficult to see and may be reduced by the enema without the diagnosis being made but this is not an important mistake, except statistically. Characteristically, as first described by Ladd in 1913, the defect produced by an intussusception is concave orally and it is encountered somewhere in the colon. As filling of the colon progresses, some barium usually passes beyond this point between the two outer layers of bowel.

It is now recognized that a high percentage of acute intussusceptions can be completely and safely reduced by the barium enema method. Once a typical defect has been encountered the administration of the enema is continued. Usually the defect can be made to pass in an oral direction quite easily. Reduction tends to progress spasmodically and not infrequently it is possible to fill the cecum and appendix well before the residual defect in the colon disappears. Before reduction can be considered complete the defect in the colon must be reduced and a considerable amount of the terminal ileum must be flooded with barium.

If reduction does not occur reasonably soon it is usually wise to allow the patient to evacuate and to wait a few minutes. Then it is permissible to administer a second enema. Occasionally even a third enema may be given. However, attempts at reduction should not be unduly prolonged, particularly in cases where the history points to an intussusception of considerable duration.

Following reduction of an intussusception the patient is kept under close observation for at least 24 hours. If reduction by barium enema is impossible operative interference should be instituted immediately.

Dr. Childe is associate professor of radiology at the University of Manitoba.

3. Surgical Management

C. W. Clark, M.D.

Some 24 cases of intussusception are seen each year at the Winnipeg Children's Hospital. Next to appendicitis, intussusception is the commonest cause of an "acute abdomen" in young children and infants. Under one year of age intussusception is commoner than appendicitis.

The surgeon usually sees the case of intussusception in hospital in consultation with the pediatrician. Dr. Medovy has outlined the symptoms and signs of this condition. In about 85 per cent of cases, a mass, sausage-like in shape, can be felt along the course of the colon. The right lower quadrant has been carried upward into the ascending or transverse colon by peristalsis. Rectal examination may reveal blood on the finger or the apex of the intussusception may, in late cases, be felt with the examining finger. These babies are always in some degree of shock and dehydration.

Dr. Childe has described the findings using barium enema and also the method of reducing intussusception by this enema.

The indication for operative treatment is present when the diagnosis has been made, unless the radiologist is convinced that complete reduction has been accomplished, and the barium fills up the terminal ileum. These cases should be kept under observation, and if symptoms recur operation should be performed. With these precautions, and a competent radiological staff, surgery may not be necessary in about one-half the cases admitted to hospital.

Pre-operative measures: Intravenous fluids should be given or a blood transfusion started and continued during the operation in shocked patients. This can be done by a "cut-down" or scalp vein technique. There should only be sufficient delay to treat shock because of the risk of the intussusception becoming irreducible or gangrenous. A nasal gastric tube should be inserted pre-operatively and suction established.

Operation: The abdomen is opened by a right rectus incision. Several fingers are inserted into the abdomen and the intussusception milked backwards towards the cecum. Then it can be delivered from the abdomen and the reduction accomplished by gently squeezing out the invaginated bowel. When the reduction is completed and the bowel is seen to be healthy, the abdominal wall is closed in layers. Appendectomy should not be done because this increases the mortality rate.

In some late cases the intussusception is found to be irreducible or, if reduced, the bowel may be gangrenous. In these cases resection is indicated. This may be done by primary resection — that is, removing the involved portion and suturing the bowel together again — or in very ill patients the involved segment is exteriorized and cut off, after the wound has been closed around it. This latter method is called a Mikulicz type of resection. In this form there is a discharge of ileal contents onto the abdominal wall. In these cases the bowel opening should be closed as soon as possible (in about one week) to prevent prolonged loss of intestinal fluid, with its resultant biochemical and electrolytic disturbance.

Post-operative care: Intravenous fluids will be required for two or three days, until there is an adequate intake by mouth. Gastric suction is continued during the first day.

Prognosis: If operation is done within the first 24 hours, the mortality should be zero. After 24 hours the mortality rises sharply with each hour.

Recurrence: Intussusception recurs in about 2 per cent of cases subjected to operation. I have operated on one patient three times in a period of one year for recurrent intussusception.

Dr. Clark is assistant professor of surgery at the University of Manitoba.

4. Nursing Care

EVELYN TURNER

KEEN OBSERVATION AND ALERTNESS on the part of the nurse are important factors when one suspects the presence of an intussusception. A careful description of vomitus, stools, and the infant's behavior during a spasm of pain serve to help the doctor make an early diagnosis. Accurate recording of fluid intake is essential. If dehydration occurs parenteral fluids should be given.

The care of an infant after surgery is not unlike that given after other types of abdominal surgery. The nurse should promote active and passive movements especially turning from side to side, although it may be necessary to limit this during the time the infant is receiving intravenous therapy. The dressing should be checked for oozing and protected from moisture as deemed necessary. Analgesics may be required during the first few hours after operation. The nurse should record all voiding and note any abdominal distention. The first stool, post-operatively, is a welcome event as it indicates the resumption of peristalsis. Following this the infant may be returned to full diet for his age and thereafter enjoy a comfortable convalescence.

Miss Turner is a head nurse and instructor in pediatrics at the Winnipeg Children's Hospital.

Spina Bifida

LEE HARRISON

SPINA BIFIDA is one of the more frequent congenital anomalies of the central nervous system. The laminae of the vertebrae which form the bony arch fail to unite, leaving the membranes covering the spinal cord exposed and unprotected. The cause of spina bifida has not been definitely determined. It is believed to be a developmental defect often associated with other deformities. The types are distinguished by replacing fluid removed from the sac, with oxygen, and taking radiograms. There are numerous classifications but there are three main types of spina bifida that are more frequently encountered by the nurse.

The most common but least serious type is the *spina bifida occulta.* Generally, the skin and spinal cord have never become completely separated and a firm band of fibrous tissue passes through the defect. Occasionally the skin is made conspicuous with an overgrowth of hair. There are varying degrees of severity — some with no symptoms or with only nocturnal enuresis; others with muscle weakness and wasting. Of clinical importance is the fact that the fibrous band does not increase in size proportionately to the growth of the spinal cord and column. Consequently, patients may not be referred for treatment until adolescence at which time complications first become obvious, due to the compression of the cord.

Spina bifida with meningocele consists of a tumor in which the membranes but not the cord protrude. This type readily conforms to surgical treatment as neurological abnormalities are uncommon.

In the *meningomyelocele type,* which is the most serious type, the membranes and often the spinal cord protrude through the bony defect. The child with this type of spina bifida usually shows other grave developmental defects. The condition is never amenable to surgical treatment. Therefore, conservative treatment consisting

Mrs. Harrison is on the staff of the Shriners' Hospital, Winnipeg.

of good general nursing care with the possible correction of other existing deformities is all that is possible.

With meningomyelocele spina bifida there are multiple associated malformations. When the number of vertebrae is diminished or they are malformed, congenital scoliosis or kyphosis results. Internal hydrocephalus is a common accompaniment. Sometimes paralysis may be complete with contraction and muscular wasting; or it may be limited to a single limb, producing talipes. Other frequently associated but unrelated anomalies are cleft palate, congenital dislocation of the hip, loss of normal function of the bladder and paralysis of the anal sphincter.

Conservative treatment of these infants and children involves protection from injury, infection and pressure. Should the membranes rupture, the result may be fatal. The site must be covered with sterile dressings and protected from urine and feces, as infection may lead to meningitis. Care to prevent excoriation of tender skin becomes necessary. Cleansing with oiled cotton each time diapers are changed will keep the skin in good condition. Pressure on the nerves must be avoided in order to prevent paralysis of the lower extremities as well as the bladder and rectum. The infant should not be turned on his back and should be supported by a small pillow or rolled blanket. In some instances, placement on an infant Bradford frame facilitates care, exposes the tumor, and prevents pressure on it. To keep the infant in position, ankle and chest restraints are used. The baby's general health must be maintained since he is readily susceptible to infections. The prognosis for these infants is not optimistic. Surgical repair is undertaken in specific instances and may be beneficial.

Surgical intervention consists of plastic repair of the meningocele sac. In all cases of simple and uncomplicated meningoceles, surgery is the preferred treatment. Optimum time in the average case is three or four months following birth. If the sac is so thin that a rupture is imminent, earlier emergency operation may be performed. Usually, when ulceration of the tumor wall is present, it is necessary to wait until complete epithelization is well established with meticulous skin care and treatment. Any infected area or ulceration of the sac may originate a fatal meningitis. Cases with moderate abnormality, like the meningocele type, usually recover well. Meningomyelocele types are nearly always inoperable. Operations for spina bifida, when advisable, may be carried out on older children when they are more able to withstand a complicated dissection. Other contraindications, where surgery would bring no improvement, are: complete paralysis; marked internal hydrocephalus; complete rachischisis, where the spinal cord is exposed with little or no sac covering.

Pre-operative nursing care consists of maintaining an optimum nutritional state and careful skin preparation. More frequent feedings may be necessary. During the pre-operative period, the infant should, when possible, be held for feedings. It gives him needed position change and affection, and facilitates feeding and bubbling. He must be handled gently, for the tumor area is sensitive. The nurse should be guided by the doctor's orders regarding preparation of the skin for surgery. Absolute cleanliness and wholesomeness of surrounding tissue must be ensured.

The most diligent nursing care is required post-operatively. Control and reporting of hemorrhage is absolutely essential. The next most important factor is the prevention of chilling due to the involvement of the coverings of nerve tissue. If the infant's temperature is subnormal and unstable, a frequent tendency, a light should be placed over him and his bed covered with blankets, thus encasing the child in a heated unit. Incubator care may be indicated. Other usual precautions following surgery must also be followed. Immediately after the operation, the patient is moved to his bed without any change in his prone position with the head lowered 3 to 5 inches, in order to prevent loss of cerebrospinal fluid. Until the wound is healed the baby is kept prone, the feet being tied to main-

tain position. The dressings must be carefully observed, kept dry and uncontaminated. This is especially important in cases where the tumor is located on the lumbosacral area. Feedings are resumed as soon as the infant will tolerate them. If possible, breast milk is recommended with additional small amounts of fluids given frequently by bottle.

After the wound is well healed, the head of the crib is elevated. If hydrocephalus develops as a complication the head is kept elevated as much as possible and later the infant is carried erect, never horizontally. The fluid intake is reduced to a minimum and the diet is changed to solid food as soon as possible.

In all cases the quality of nursing care has a direct bearing on recovery and the prevention of more serious complications. Since, in many cases, surgery is performed in the early months the mother will need help in understanding the total needs of her child. The infant has been born with an anomaly. The development of wholesome attitudes toward it can be influenced by the nurse. The emotional security which a baby finds in his parents' love often compensates for physical handicaps. Help the mother to know what is desirable, how to accomplish it and to realize that a child, even a tiny baby, is an individual. The child in a happy home is likely to have better mental and physical health than the child in an unhappy home or in an institution where material conditions would be excellent. Together, mother, nurse and physician can work out a satisfactory plan to best meet the infant's needs.

Children's Eyes

ELIZABETH VAUGHN

THE EYES of a baby, at birth, are about two-thirds as large as they will be when they are full grown — when the child is eight or nine years old. Right in the middle of this period, while the eyes are still immature and easily damaged, the child is tossed into the hopper of school life and required to concentrate its vision on printed words. That concentration is one of the most exacting tasks to which eyes can be subjected.

The first thing for the parents of a five- or six-year-old to remember is that they should not expect those young eyes to work on print, or any other small objects, except for brief periods with rest periods between.

Young children are naturally farsighted. They can see distant objects more clearly than nearby objects. Anybody, young or old, is farsighted if his eyeball is too short from front to back. Because a young child's eye is small, it can hardly help being too short, hence its farsightedness. The child can, however, force itself to see small, close-up objects because its eyes have a remarkable power of accommodation.

The shape of the wonderful little lens in the eye can be changed to form a clear image on the retina. Changing the shape of the lens, and holding it there, is hard work for the delicate ciliary muscles. It may produce eye-

Frowning and squinting are a sign that a child's eyes need help.

This material was contributed by the Better Vision Institute, Inc., New York City.

strain and permanently damage the eye. So a youngster is not just being perverse, or showing a dislike for reading, when he keeps glancing out of the window instead of fixing his gaze on the book. He may be saying, in effect, "My eyes are tired."

Read he must, sooner or later, and a wise parent can do a great deal to cultivate a love of reading before the child can actually read a word. There can be the game of playing with books and pictures at home, under a good, diffused light. Be sure it is *big* print. Even more alluring is the trick of reading stories and rhymes aloud to the child and encouraging him to "make believe" that he himself is reading. This means that two persons must look at the same book. Care should be taken that it is in the proper position before the eyes of both — about 15 inches away and held upright. The book should be closed and the eyes rested at frequent intervals.

Growing children are interested in outdoor games, sports, and contests. They are apt to be good at that sort of thing because it suits their seeing powers. It is fortunate that this is so, because games and outdoor activities make for gregariousness, good fellowship, ability to get along with people, and a sense of teamwork. Occasionally, however, a child's eyeball is not too short but too long. Then he is nearsighted. Such a youngster is likely to be a bookworm, ill at ease with people, a poor performer at games. While the bookishness is probably something to be prized, the tendency to avoid people is not. In such cases, a pair of glasses for distant vision, that will enable a boy to hit a baseball, may be a wise investment in the child's welfare.

Not until the late teens, as a rule, is youthful farsightedness completely outgrown. Sometimes the process goes too far — the eyeball becomes a little too long and nearsightedness, or myopia, results. That, too, may indicate the need of glasses.

School children are not only affected by possible farsightedness or nearsightedness buf by astigmatism, a totally different eye condition. It usually results from a slight malformation of the cornea. As long as a boy's activities consist mainly in hitting baseballs, his astigmatism may not bother him. When he applies his eyes to the printed page it may cause trouble if it is a pronounced case. As a rule it can easily be corrected with spectacles.

It is obvious that a great deal of care is needed to make sure that a child's eyes are in good working order. Most schools go no further with eye examinations than the well known Snellen test, which discovers how well a child can read type of various sizes at 20 feet distance. Even if the score is 20/20, or so-called normal vision, that tells nothing about the child's ability to see at 15 inches, or to focus first on the blackboard and then on the desk work, or whether there is a trace of squint.

The solution is for the parents to be alert for symptoms of eyestrain. Authorities declare that a child should have an eye examination by a competent specialist at the age of three or four, another on entering school, and still others at stated intervals during his school career. This looks like a lot of bother and expense but, after all, those eyes must last a lifetime.

Nursing Sisters' Association

Covers were laid for 36 at the annual Remembrance Day dinner of the *Saint John (N.B.) Unit* at the Admiral Beatty Hotel. The president, Lyla Gregory, welcomed the members and made appropriate reference to the occasion. Those at the head table included: Misses A. Burns, M. Boyle, A. Carney, Mmes D. Dryer and J. Wilson. Bridge was played later.

April Fool's Day

Long ago, when the year began in the Spring, there was a Feast of Fools at the time of the New Year. When it was decreed that the year would begin on January 1, there were those who refused to move with the times. They came in for considerable teasing and "New Year's" gifts were sent to them on April 1, accompanied by cards that read: "April Fool."

Our Nurses Serve the World

OLIVE BAGGALLAY

YOU MAY BE tempted to think sometimes that the pioneer days of nursing belong to the last century when Florence Nightingale and her small band of women went to the Crimean War. In our profession, however, there is still room — plenty of room — for the pioneer spirit. Let me tell you something about our WHO nurses and their colleagues who are working at the present time in many different countries of the world.

They are as yet only a small group of about 140 but they are picked people. They come from many different parts: from North and South America, from North and West Europe, from Greece, Italy and Germany, and some also from India and China.

One of our earliest recruits was HULDA WENGER from Vevey, Switzerland. She was working with UNRRA in Ethiopia when the Interim Commission of WHO recruited her in 1948. She continued her work there until the first school of nursing in that country —the Red Cross School of Addis Ababa — was well started.

Hulda took her nursing training in Zurich. She has a flair for international work. She has that understanding, sympathetic approach that makes people give her their confidence at once. She also has a persistent conviction of her nursing principles which conveys itself easily to those working with her.

Hulda has spent the past three years in Borneo — first in Kuching, Sarawak, and now for two years in the little known country of Brunei.

Brunei is rich in native products but poor in technical skills. Its peoples are not far removed from their head-hunting ancestors and have had little opportunity for education. They are in need of health services and nurses.

The government of Brunei has recently developed a chain of health centres and some travelling clinics along their main highway, the Brunei River, and has trained some local people to serve these centres. A 200-bed hospital has also been built with a large out-patient clinic in the capital town.

Hulda's job has been to help train local girls and boys for nursing work in the hospital and the health centres. It has had to be a simple, practical training suited to their understanding. Of course it has had to be done in cooperation with the local staff and in the local language. Nevertheless, 16 keen young people have completed a one-year course and 16 more are in training. The best of the first group have been allowed to specialize either in midwifery or in general hospital or public health work.

It has been a surprise to Hulda that, once their interest is aroused, these young people learn very rapidly and are able to remember what they learn. They are showing real aptitude for nursing and are developing a responsible attitude to their work.

* * *

WHO nurses are doing a great variety of things in many different countries. They always work with the local nurses. The government attaches one or two of their best nurses to work with the WHO people as national counterparts. In this way the WHO nurse learns the particular methods and problems of the country and each can add to the other's understanding of the best way to do the immediate job. There is a very real development

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Miss Baggallay, who received her training at the Nightingale School and at King's College, London, was formerly instructor in public health nursing administration at Bedford College for Women, London. Later she became public health nursing officer, British Ministry of Health, and during 1944-46 was chief nursing consultant for the United Nations Relief and Rehabilitation Administration mission in Greece. She is now chief, Nursing Section, World Health Organization.

here in international understanding and professional fellowship.

ETHEL LOUISE PEPPER from Pietersberg, South Africa, is a public health nurse. In 1949 she joined a malaria control demonstration in the Terai region of North India. This was a fertile district that had been at one time a well-populated, rich country, but was gradually returning to jungle because the people were dying off with malaria.

Ethel and the Indian health visitors had the job of converting the shy, suspicious villagers to the idea of cooperating with the malaria team, of preparing their houses for the seasonal DDT spraying, and of bringing their sick children for treatment. That was comparatively easy. It was more difficult to persuade the women to allow the nurses to take a drop of blood regularly from each baby in order to test it for the malaria parasite.

But nurses can always find ways of winning a mother's confidence! At each visit they set up a primitive nursing corner under a tree in the centre of the village. There they provided some first aid for the little accidents and troubles that are always present. They talked with the women about their problems and, incidentally, learned a great deal about the village life and customs and in particular about their health problems. After the villagers got over their first fear of strangers and saw some of the results of their work, they began to look forward to the nurses' visit and gave them a great welcome. When the first malaria season was over without the usual crop of sick babies, the team had won their way.

Even then it was no easy work. It was physically exhausting travelling through the jungle in all weathers, through tropical sun or rains to isolated villages — and most villages are isolated. They would often start from their centre in the very early morning in an attempt to get home before dark when the jungle beasts begin to roam.

The WHO team completed its function last year but the work goes on. Indian doctors and nurses continue to organize the malaria control, to extend it to other areas, and to provide some health services to the mothers and children as part of the general campaign.

* * *

Many WHO nurses are working in schools of nursing or schools of midwifery and are helping to educate the professional leaders of the future who, in their turn, will teach and supervise other nursing groups. So, in geometric progression, the acute shortage of nurses can be gradually met.

MARY HARLING left Montreal in 1951 for Penang in the Malay States and has been working in the Penang School of Nursing ever since. She is one of a WHO nursing education team consisting of four instructors, one of whom is a male nurse, JOHN WATERER, from London, England. They are helping the Penang school staff to improve the teaching and to include in the program a sound preparation for the sort of work the Malay nurses have to do — health teaching, children's nursing, school nursing, midwifery and (for the men) rural dispensary work. This term they have in all 101 pupils, drawn from many of the States.

Penang is a beautiful island in the tropics, with cool sea breezes and a mountain area where one can escape for rest. The hospital attached to the school is a good building with modern services and the health centres in the area give excellent learning opportunities for the student nurses.

Mary has a heavy teaching schedule in the preliminary school where she shares with the local tutors the introductory teaching for three classes of 36 new students yearly. The response she gets from these keen and intelligent young men and women gives her the real satisfaction of a job well done.

* * *

The cooperation of WHO with a nursing school often focuses public interest on nursing and raises it in the public estimation. This proved to be the case in the San José Hospital, Costa Rica, where three WHO instructors have been working since July, 1951.

At the end of the first 18 months the school authorities took the bold deci-

sion to charge tuition fees to their students instead of paying them as employees of the hospital. The reputation of the school was greatly enhanced and parents withdrew their objections to their daughter's choice of nursing as a career. The results of this decision have been encouraging — more and better candidates are applying.

In countries like Costa Rica and El Salvador, where nursing is only starting, the few educated girls who take it up must be prepared for pioneer work in their profession. They must undertake to train and supervise auxiliary workers and act from the beginning as administrators and teachers.

JEANNETTE PITCHERELLA is an American nurse of Italian origin. Languages come easily for her. She learned Spanish especially for her work with WHO in El Salvador. In June, 1951, she joined the international team working in the Health Demonstration area there. She has been helping the local nurses at the main Quezaltepeque health centre to set up a training course for auxiliary nurses and midwives. Quezaltepeque is the market town for the large and fertile valley of San Andrea which has been selected for a demonstration of an integrated health program.

To combat malaria and other prevalent diseases, to work with the villagers on their health and sanitation problems, and to provide assistance to the women in the care of their children, many more nurses are needed. Jeannette, helped by her local counterparts, has selected and trained local girls for this work. When trained, they are placed in the small village health centres where they are regularly visited by the doctor and nurse from Quezaltepeque centre.

The valley also received help from the other specialized agencies of the UN in improving farming techniques, developing labor practices, and organizing a big literacy campaign. It must be a rare privilege to work in such a setting and to be one of a pioneer group in a country with such possibilities.

* * *

MARIA TITO DE MORAES comes from Lisbon, Portugal. She is small, dark, with real charm. She has command of three languages at least. At the request of the Syrian Government, she has been attached to their Ministry of Health since 1951 as a nursing adviser. It has been her task to help the medical advisers in the Ministry make plans for the future of nursing in their country.

First there was the planning of the new university hospital, the nurses' home, and the school of nursing buildings. Then there were the adaptations needed in the old hospital to provide facilities for nursing care, such as duty rooms and cupboards. Next there was immediate work to be done with the hospital nursing staff under the leadership of Miss Fadel, the matron, in order to provide better nursing care for the patients. The hospital nursing procedures have been rewritten and the conditions of employment improved.

The newly formed Nurses' Staff Association has collaborated in these plans and has been an important element in forming a national association of Syrian nurses and midwives. A nursing law has been through many drafts and revisions and is now before the government for approval.

Activities, however, have not been confined to Damascus. Outlying hospital and health centres have been surveyed and plans made for the development of more schools of nursing.

* * *

I have only to shut my eyes to be able to picture the many other nurses whose vivid reports cross my desk daily and who give me such a warm welcome when I manage to get away to visit them with our regional nursing advisers. Theirs is no routine job. It calls for initiative and conviction. It also calls for real physical endurance.

Nursing today is still pioneer work and no country in the world has yet reached the point when the nurse's job is a static one. Our WHO nurses know this and their experience abroad is giving them wonderful opportunities to think about the developments in their own country. They will return home with renewed insight.

Nursing Profiles

Daisy Caroline Bridges, R.R.C., the indefatigable executive secretary of the International Council of Nurses, received well merited recognition in the Queen's New Year Honors List when she was made a Commander of the Most Excellent Order of the British Empire — C.B.E.

A graduate of The Nightingale School, St. Thomas's Hospital, London, Miss Bridges had already made a distinguished success of her career in nursing before she joined the I.C.N. staff in 1948. Her record of service with the army during World War II was impressive as she rose in rank to become command matron. Prior to the war, she was resident tutor for the Florence Nightingale International Foundation. When the British Ministry of Health established the Working Party to consider recruitment and training of nurses, Miss Bridges gave valuable assistance.

Though she has not yet visited Canada in her present official capacity, Miss Bridges is well known to many Canadian nurses. Their sincere congratulations are extended to this eminent leader.

This past year has seen the appointment of three new members to the faculty of the University of Toronto School of Nursing.

Otley, London, Eng.

DAISY BRIDGES

Margaret McPhedran, who was appointed assistant professor, is a graduate of Englehart Hospital, Petrolia, Ont. After a brief period in private nursing she studied teaching and supervision at the University of Toronto, returning later for a year of study in nursing education. She holds a Bachelor of Arts degree from the University of Toronto and a Master of Arts degree from Teachers College, Columbia University. Professional experience has included positions in schools of nursing in Saskatchewan and Ontario. Miss McPhedran assisted with the Canadian Nurses' Association demonstration school of nursing in Windsor, Ont., the funds for which were provided by the Canadian Red Cross Society.

Margaret MacLachlan is a graduate of the University of Toronto School of Nursing having received her Bachelor of Science in Nursing degree in 1947. For three years she served in the Red Cross outpost hospitals in Ontario. Following this pioneer work, she was employed with the Victorian Order of Nurses, then with the county health units. Until recently she was director of nursing, Simcoe County Health Unit. Miss MacLachlan is assisting with the teaching of public health nursing.

Lyaine Sauve returned to the school as a lecturer. A graduate of the basic degree course in nursing in 1949, Miss Sauve assists with the teaching of nursing in the basic course. After three years' experience with the Victorian Order of Nurses she was on the staff of the hospital in Temiskaming, Que., prior to her present appointment.

Gertrude E. Bundy is now the director of nursing of the Kitchener-Waterloo (Ont.) Hospital. Following graduation from the E. J. Meyer Memorial Hospital in Buffalo, N.Y., Mrs. Bundy studied hospital administration, including teaching and supervision. Marriage interrupted her career in 1927. When she returned to active nursing 14 years later, she engaged in public health work in Dansville, N.Y. Further preparation in hospital administration preceded

Mrs. Bundy's acceptance of the post of administrator of the Dansville Memorial Hospital. Since returning to Canada in 1952, she has been director of nursing at St. Andrew's Hospital, Midland, Ont., and the District Memorial Hospital, Tillsonburg.

Associated with Mrs. Bundy at Kitchener-Waterloo Hospital are **Ella (Yates) MacDonald** as administrative assistant director and **Jean Cameron** as supervisory assistant director of nursing service. Mrs. MacDonald is a graduate of Royal Jubilee Hospital, Victoria, and of the course in administration in schools of nursing given at McGill School for Graduate Nurses. A graduate of K.W.H., Miss Cameron took some post-graduate work at the University of Pittsburgh. Both have had lengthy experience as head nurses and supervisors.

Dora Hope Arnold, who has been director of nursing at the General Hospital, Brantford, Ont., since 1937, is retiring from active duty for reasons of health. Miss Arnold's professional activities have been closely interwoven with B.G.H. since her graduation there 28 years ago. Two years of private nursing were a prelude to her return to the hospital as operating room supervisor. After receiving her certificate in teaching and supervision from the University of Toronto School of Nursing, Miss Arnold returned to her alma mater to be instructor and clinical supervisor until she assumed the duties she is now vacating. She has always taken an active interest in nursing association affairs, giving leadership in committee activity. An accomplished musician Miss Arnold will now have more time to devote to her favorite hobby — scrapbooks.

In Memoriam

Anna J. Breen, who graduated from St. Luke's General Hospital, Ottawa, Ont., in 1910, died suddenly on January 17, 1954. Miss Breen's professional activity was in the private nursing field in Ottawa.

* * *

Irene Cains, a Montrealer who graduated from St. Luke's Hospital, New York, died in Montreal in January, 1954, at the age of 68, following an illness of several months. During World War I Miss Cains served with the C.A.M.C. in France and in the Mediterranean area, receiving the R.R.C. At war's end she became nurse for several world cruises then spent some time in South America as nurse with an oil company. In 1924 she left nursing and joined the editorial staff of *The Gazette,* a Montreal newspaper. For more than a quarter of a century she was the social editor of that paper.

* * *

Irene (Lynch) Campbell, who graduated from St. Joseph's Hospital, Peterborough, Ont., in 1946, died on November 24, 1953.

* * *

Katherine Cole, who graduated from the Moncton (N.B.) Hospital in 1946, died on August 19, 1953, at Tatamagouche, N.S., where she had been matron of the Lillian Fraser Memorial Red Cross Hospital for the past two years. She was in her 31st year. Previously, Miss Cole had engaged in general and private nursing.

* * *

Jane Elizabeth Elliott, who was in the third year of her training at the General Hospital, Guelph, Ont., died on January 28, 1954, at the age of 21.

* * *

Henrietta Fisk, who graduated from the Western Hospital, Montreal, in 1896, died in Peterborough, Ont., on January 23, 1954.

* * *

Edna Jane (Smith) Giffin, who graduated from The Montreal General Hospital in 1913, died at Vancouver, B.C., on January 5, 1954, at the age of 72. Mrs. Giffin had served overseas with the Canadian Army Medical Corps during World War I.

* * *

Nina Beatrice Hamilton, who graduated from the General Hospital, Brockville, Ont., in 1921, died at St. Marys, Ont., on July 26, 1953, in her 52nd year. Following graduation, Miss Hamilton specialized in x-ray and laboratory work and engaged in these fields in her own hospital, where also she was assistant superintendent for a number of years. She joined the staff of the St. Marys Hospital in 1950.

* * *

Marjorie Laura (Black) Nelson, who

graduated from the Toronto General Hospital in 1930, died at San Diego, Calif., on January 7, 1954, after a lingering illness. She was in her 49th year. Following graduation, Mrs. Nelson engaged in private nursing until her enlistment with No. 15 Canadian General Hospital Unit in World War II.

* * *

Gwen Nichol, who graduated from The Montreal General Hospital in 1908, died at Montreal in January, 1954.

* * *

Rose Olafson, who graduated from the Regina General Hospital in 1926, died suddenly at Rosetown, Sask., on January 16, 1954. Following graduation, Miss Olafson engaged in private nursing in Regina for several years. She held administrative positions in the hospitals at Foam Lake and Indian Head, Sask. In 1943 she joined the Rosetown Clinic as receptionist and office nurse.

Anna Schwarzenberg, who was executive secretary of the International Council of Nurses from 1935 until 1947, died in Austria on January 11, 1954. Graduating in Vienna in 1926, Miss Schwarzenberg took the course in nursing administration sponsored by the League of Red Cross Societies at Bedford College, London, England. She returned to Austria and served as matron of the Children's Hospital in Graz until she accepted the I.C.N. appointment. Until last year, she had lived in Vermont. Illness and an impending operation persuaded her to return to her family. Miss Schwarzenberg will be well remembered for her notable contribution in promoting unity and understanding among nurses the world over.

* * *

Katherine A. Stewart, who graduated from The Montreal General Hospital in 1914, died at Renfrew, Ont., on October 18, 1953.

Keep Your Balance

Eight-point refresher course on how to keep your balance in a world of tension:

Don't allow yourself to be pressed into an ever-narrowing circle of interests and activities. It is only by pushing the circumference of that circle outward into the world that emotional balance can be maintained. This applies to all facts of life: work, recreation, social activities, and physical well-being.

Emotional unbalance is often due to preoccupation with perfection. And, sadly enough, the closer we come to perfection, the less satisfied we are with it. The least hint of imperfection is enough to upset our mental outlook.

The value of a hobby is beyond question. Many a person finds the mere fact of having a piece of wood in a vise, or a stamp collection in a book, or flowers in his garden — something that is his by creation or organization — has given him an aid to mental poise that is of priceless value.

Do not plan in fear and review with regret. It is better to plan carefully, to perform joyfully; to review critically but calmly, and then go on to new experiences with buoyant anticipation.

We all have periods of lowered mental health. The hazards are different at different ages but if we take our bearings in each age bracket and heed the signs, we can assure ourselves of the topmost satisfaction and happiness available to us.

Meet problems with decision. Work out a plan of analyzing them so as to know their real nature; make a plan to solve them; and then quit thinking about them.

Have the serenity to accept things you cannot change. You can't escape adversity but don't let it bowl you over. Practise saying the cheerful, useful thing; avoid saying mean things however much you want to.

And finally: *Quit looking for a knock in your motor every day.* Learn to like your work, thus escaping tension and gaining satisfaction. Learn to like people; don't carry grudges or dislikes.

— *The Teacher's Letter*

Enough if something from our hands have power
To live and act and serve the future hour.
— WORDSWORTH

In nothing do men approach the gods more closely than in the bringing of health to mankind.
— CICERO

Accident Prevention in Infants and Preschool Children

MARY WILSON, B.Sc.

ACCIDENTS IN ALL FORMS cause more deaths each year than any single known disease. In Canada, more than 2,000 children die needlessly each year from this cause.[10] Thousands of other children suffer injuries, temporary or permanent, to their fingers, arms, legs, and head. Physical pain and misery accompany each accident. The prevention of accidents is a public health problem and, as such, a responsibility of the public health worker.

Vital Statistics in Canada over a five-year period show, in the age group 0 - 4 years, 91,228 deaths from all causes. Of these 4,140 were classified as accidental.[8] A more detailed study shows that accidents are the third commonest cause of deaths in children of all ages, the fourth commonest cause of deaths in children under five years of age, and by far the commonest cause of death in children five years of age and over.

The following table summarizes the types and percentages of fatal injuries which occur in the ages 1-4 :[7]

TYPES OF FATAL INJURIES

Ages 1 to 4

Per cent of all Injuries

Motor vehicles	35.8
Burns and conflagration	28.2
Drowning	11.3
Poisoning (by liquids and solids)	5.1
Falls	4.6
Choking (by objects or food)	4.2
Others	10.8

(Metropolitan Life Ins. Co., 1948-49)

Although there has been a steady decline in accident mortality in the past 25 years, the preschool child's chances of death from accidental injury has decreased less rapidly than his chances from other causes. Four-fifths of accidents to children under five years have been ascribed to errors of adults. About two-fifths of the deaths from various types of accidents among preschool children occur in or about the home.

Studies indicate that susceptibility to certain types of accidents is largely dependent on the age factor — that is, certain types of accidents are more likely to occur at one stage of a child's development than at another. Some children seem to have accidents over and over again and evidence suggests that these might be caused by physical or emotional conditions.

SUFFOCATION

Under one year the most important single cause of accidental death is suffocation. Recent studies note that smothering is rarely the cause of death commonly certified as due to accidental mechanical suffocation. Dr. Gaylord W. Graves states: "It is particularly easy to confuse the picture of shock and fulminating respiratory infection with that of suffocation."[9]

To safeguard infants who are helpless and depend solely on adults for protection, certain precautions are advisable to reduce this hazard of suffocation by bedclothes or wearing apparel. A pillow should be dispensed with. Besides being bad for the baby's back and, later, his posture, it might become misplaced and the baby's face be covered by it. If for any reason it is necessary to elevate the baby's head and shoulders, a folded blanket or magazine placed under the mattress

Miss Wilson is a public health nursing supervisor in Winnipeg.

will achieve the desired result. Extra bedding should be removed from the baby's bed especially at night. When making or changing the bed, tuck the sheets and blankets well under the mattress particularly at the foot so the baby cannot pull them up as he moves about.

Tapes securely sewn to the corners of the sheets and blankets provide a satisfactory way of anchoring the covers to the crib. If the baby's blanket is too long, tuck it under at the foot of the bed; do not fold it under his chin. It might become loosened and flap up over his head. If the bed is too long, place the baby with his feet nearly at the bottom, so that there will be no chance of him sliding towards the foot and under the covers.

The bars in the crib should be so spaced that there is no danger of the baby's head getting wedged in between. The sides of the crib must be kept up at all times. Toys should be large enough that he cannot put them into his mouth. Avoid toys with small removable parts — as glass or button eyes in stuffed dolls and animals. It is also important that paints containing lead be avoided in refinishing toys, furniture, and other articles that babies are apt to suck. *Lancet*, for November 8, 1952, reported the death of an eleven-month-old boy as a result of the ingestion of paint that he had chewed off his bed. The original paint used by the manufacturer had been harmless but the child's parents had later applied paint containing lead.

If sleeping bags are used, they should be so constructed as to allow freedom of movement without danger of choking or exposure. To eliminate the danger of babies choking to death from regurgitation of food, they should be picked up and held in a semi-recumbent position with the head slightly elevated during the feeding period. After feeding, sufficient time should be allowed for burping of air-bubbles before being put down.

Drownings

The high rate of accidental drownings — 22 per cent of all deaths from accidents in the younger age group — emphasizes the helplessness of these children in water.[3] For this reason they must never be left alone in the bathtub at any time. The following story emphasizes the need for exercising such safety rules:

> A mother who was conscientious about always having her husband's supper ready on time decided that she could leave her two sons, Johnny 4 and Jimmy 2, to play in the bathtub while she ran down to the corner store for some groceries. She thought she would only be away for five or ten minutes. As soon as his mother had left, Johnny decided to turn the tap on. When the water level became too deep for him, he climbed out, leaving his brother to drown. The mother's desire to get things done in a hurry resulted in this tragic death.

Adequate supervision should be provided at all times for small children when they are playing in and around pools, ponds, and cisterns. Water holds a strange fascination for them. Where at all possible, and particularly on farms, water-holes, ponds, cisterns, etc., should be fenced in or covered. Water toys, such as rubber tires, animals, wings, etc., which are sold as playthings, may become the cause of accidental drownings. The child may drift too far out into deep water and then become panic-stricken when he realizes where he is. Children should never use these toys unless they are being supervised by an older person.

Falls

From the stage of being solely dependent on adults for his needs, the child moves into the stage of exploration and "let's pretend." We can think of many hazards that the inquisitive child can get into when he attempts to get at an object considered inaccessible or into situations considered impossible. Children need freedom to move about but they also require safeguards such as gates at the head and foot of stairways, and firm, properly fastened screens to protect open windows. Guard rails on stairways will help them keep their balance as they go up and down.

Because most childhood accidents

are not fatal and go unreported, the real significance of available statistics in the implication of home carelessness cannot be calculated. However there is evidence to prove that the kitchen is the most dangerous room in the house.

In the Home

The *kitchen* would appear to be the best place to launch a drive for accident prevention in the home. A survey reveals such hazards as electric toasters, irons, mixers, electric cords and sockets; sharp-edged utensils such as knives, can openers, ice picks, scissors; stoves, matches, cigarette butts; containers with hot liquids; poisons such as cleaning fluids and insecticides.

Burns have been responsible for a large percentage of accidents. Matches should be kept in a metal container and out of reach. Pot handles should not be allowed to protrude over the edge of the stove. It takes only the slightest contact with the handle to spill the contents of the pan. This can easily mean an accident for the child who happens to be in the danger zone. A safe practice would be to keep young children out of the kitchen while meals are being prepared. Children need to be taught very early that stoves and fireplaces are spots to be avoided. Careless handling of cigarettes and cigarette ashes, improper use and storage of cleaning fluids, are other fire hazards.

Housewives should realize that volatile liquids, such as gasoline, benzine, naphtha, have a vapor that is heavier than air and seeks a lower level; that an open flame need not be near the volatile liquid to cause trouble and that the vapor, when mixed with air, forms a high explosive as powerful as dynamite. Studies of hospital admission records show how rare it is for a second case of severe burns to come to the hospital from the same home. But what a tragically expensive way of teaching parents how to prevent death and injury to their children!

Scatter mats should be discarded, particularly at the head and foot of stairs, unless they are firmly anchored to the floor by non-skid material. Too much wax and too little polishing will make floors slippery. Wax should be used sparingly. If it is the kind that requires buffing it should be rubbed down to a hard, dry finish. Water or grease spilled on the floor should be mopped up at once.

Electric appliances should be disconnected immediately after use and placed out of reach of tiny hands. Electric wiring and equipment should be examined frequently for possible breaks. Open wires can cause fire and, possibly, electric shock. All unused light sockets should be capped or taped to eliminate the possibility of children poking their fingers or metal objects, such as spoons, into them. Toys should not be kept on the stairs or strewn around the floor where they can be tripped over. Misplaced furniture has often caused serious accidents especially at night.

The *bathroom* is a fascinating room to the toddler. He can turn on the water in the tub, experiment with mother's powder and lipstick or dad's razor in front of the mirror, climb on the bathtub or toilet seat to reach the medicine cupboard. There attractively coated tonic, laxative or sleeping pills are to be found, as well as germicides, such as iodine and bichloride of mercury. Children are curious and will taste anything. Any drug is a potential danger even if it is not normally poisonous to adults or in its proper dosage. The increased palatability of many products may lead the child to take an overdose, even if it is not fatal. Many drug manufacturers stress this palatability factor.

To overcome some of the hazards connected with the storage of medicines and other poisonous substances, they should be placed in containers with firmly fitting lids. In general, tablets and pills are dispensed in flimsy envelopes or cardboard boxes that are easily opened. A container with a screw top would help eliminate this danger. Poisonous drugs and germicides, etc., should be carefully marked and made identifiable even in the dark by thrusting pins through the bottle corks or by tying bells on the neck of bottles with screw tops.

There is also extreme danger in the practice of keeping drugs in containers

that normally hold something else. Children have been known to swallow iodine kept in a cod liver oil bottle, turpentine in a lemonade bottle; roach powder has been mistaken for sugar or baking powder; sleeping tablets such as amytal or nembutal for vitamins. Many more could be added to the list. The greatest protection we can offer children lies in keeping all drugs, cleaning lotions, cosmetics and tablets out of their reach, being sure that labels on the bottles are clearly marked. The slogan "Don't put it down, put it away," if practised faithfully will eliminate some of the accidents.

Motor Vehicles

As children become independent and roam from place to place, they frequently become victims of motor vehicle accidents in their own yards. They need to be taught early how to get in and out of cars. They should learn to obey traffic lights, to cross the street only at intersections, to look both ways before stepping into the street, and to face traffic if they walk on the road. Children should be taught the dangers of playing around parked trucks, cars and tractors.

Hiding Places

Discarded trunks or iceboxes with their peculiar fascination as hiding places are often the cause of needless accidental deaths. Parents and interested citizens are pressing their governments for laws that will require that all locks, hinges, etc., be removed from such articles before they are discarded.

Safety Education

When we consider that probably 90 per cent of all accidents are preventable, we realize that the home accident prevention problem is one that must be recognized and combatted by the family itself. Home safety, then, should be the concern of everyone. The most necessary step in promoting community participation in a home safety program is educating the public to its need. Safety education produces the best results when it is related to actual learning situations that require consideration of safety. Parents must assume responsibility for teaching safety to their children. Overprotection is not the answer. Minor but painful injuries can serve as positive learning situations. Careful instruction combined with intelligent precaution will achieve far greater and more lasting safety.

The public health nurse is in a strategic position to help prevent accidents by the very nature of her work. Through her daily contacts with individuals in their homes, at school or child health conferences, she must be prepared to integrate into her over-all health teaching information regarding accident prevention. If the nurse is to meet this challenge she must keep alive her own interest in the problem by continuous study of current information appearing in newspapers, magazines, safety reports, as well as her own personal experience. She must train herself to become sensitive to conditions so that she will never fail to observe potential hazards quickly and accurately. She must herself develop safe work habits.

In brief, she must learn to do what she would have others do. While safeguarding her own health and happiness, the public health nurse will automatically stimulate others to follow her safety examples. As her skill develops, she will gather a wealth of practical ideas, and possibly some interesting gadgets, to aid her in teaching others. Knowledge of her subject, power of observation, the ingenuity to offer economical and practical solutions to existing problems, and the ability to help others help themselves are well known tests of the public health nurse.

The responsibility for initiating and organizing community action may be assumed by the medical health officer or any other interested person or group. The public health nurse, besides helping to stimulate community action, can act on committees, offer suggestions for radio and television programs, newspaper releases, poster displays for hospitals, clinics, stores, etc., and give personal interviews and special talks to interested groups.

The cooperation of doctors, parents, schools, hospitals, and health departments in promoting a continuous safety

education program will help protect the children in our communities from needless deaths and injuries caused by accidents.

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In the Good Old Days

(*The Canadian Nurse* — APRIL 1914)

"It is significant that statistics show nurses to be eight times more liable to contract typhoid fever than the general run of people, and it is noted, too, that the majority of cases of typhoid fever among nurses occurs in probationers or those in their first year of training . . . Every nurse is thoroughly impressed with the idea that if she gets sick it is most likely her own fault and probably due to putting her fingers or something else contaminated in the ward into her mouth."

* * *

"Patients undergoing surgery for exophthalmic goitre go to the operating theatre dressed in their own clothes, as: Ladies — nightgown, light petticoat and stockings; gentlemen — pyjamas or under-drawers, nightgown and socks. Gauze, completely covering the hair, is tied over the head. Nightgowns are replaced with loose cotton jackets at the time of the operation."

* * *

"Mental hygiene is a comparatively new term, very admirably selected as including both the ameliorative and the preventive aspects of effort to combat mental disease... The challenge to the nursing profession to bring the ripe experience of a general training to the study of mental disease has never sounded so loudly as today. Not alone for the elevation of the standards of nursing in the institutions for the insane, but among the vanguard of the army of those who will work to overcome the prejudice and ignorance of the general public, is the highest type of nurses demanded."

* * *

"The Canadian National Association of Trained Nurses has not, so far, been really national in anything but name. This is no fault of the officers who have worked so nobly to make it national in character, in work, in representation, as it already is in aims and ideals. But the officers alone cannot accomplish all their hopes and plans for the nurses without the cooperation of the nurses themselves . . . Every local association should rise to its duty of sending one or more delegates to the annual convention. See that every delegate is ready to make her contribution to the convention and its success in every department will be assured."

* * *

"The King George Hospital for Infectious Diseases in Winnipeg was opened for public inspection on February 26, 1914 . . . Everyone expressed satisfaction with the very complete equipment."

There is always time for grumbling — however rushed one's life — but how often do we use a worthwhile segment of time for giving thanks?

Visiting in the Pediatric Department

SISTER FLEURY, SOPHIE DYMTERKO *and* HELEN LEMOINE

WHEN AND UNDER what circumstances should visitors be allowed to visit sick children in the pediatric department? This is a controversial question that has had conflicting replies. Parents and guardians would like to come more or less as they wish so restrictions are sometimes not accepted very willingly. Nurses and other hospital workers frequently are annoyed by persistent visitors and would be inclined to make regulations very severe.

The trend in the past in most hospitals has been to reduce visiting in the pediatric department to a minimum. Of recent years this trend is changing because our concept of the total care of the child has altered. We realize that our patient has other needs besides the physical ones that are essential to his recovery and to the future maintenance of his health. Those responsible for regulating visitors in the pediatric department must be guided by the fact that such rules are designed primarily for the welfare and recovery of the child. All other considerations, such as the satisfaction of the visitors or the convenience of the nursing staff, are secondary. In general, visits that help the child to adjust to his new environment and to his illness, that give him a sense of security and contentment, or that are required for his care and rehabilitation after discharge should be encouraged. Those that are detrimental to his welfare should be prohibited.

ADVANTAGES

To the sick child, parents, and staff the advantages of regular visits may be numerous and varied. Visiting usually promotes the child's recovery by helping him to adjust more rationally to the hospital environment. It makes possible the establishment of good nurse-parent relationship. The parents should be encouraged to talk with the head nurse who can keep them informed of the child's progress. The nurse, in turn, has an opportunity to observe the parent-child relationship and learn about the child's habits, difficulties, likes and dislikes and emotional stability. It is not the nurse's duty, however, to discuss the medical aspects of the child's care nor to give information as to diagnosis. This is the doctor's responsibility.

Visiting also provides an opportunity for the head nurse to discuss the importance of mental and physical hygiene both for the parents and child. When the calm, reassuring and confident parent visits, it re-establishes or increases the child's sense of security. If the parent shows confidence in the nurse, then certainly the child will feel this and react accordingly.

DISADVANTAGES

The problems encountered during and after visiting are also worthy of mention, although they are outweighed by the advantages. There is the danger of transmitting a communicable disease. For example, the parent with a cold, especially at the onset, should not be allowed to visit. Visiting quite often excites the nervous, insecure child. Sometimes it takes the nurse an hour or more to re-establish a sense of security.

The emotionally unstable, frightened parent needs help in forming positive attitudes. This does not mean that she should not come to the hospital. Daily

All of these nurses are active in pediatric nursing at the Misericordia General Hospital, Winnipeg, Man.

visits with the head nurse will do much to banish fears. Such a parent needs firm, positive and constructive relationships — never a harsh or impersonal greeting. If at all possible the parent must be taught to be brave, to face the child's illness — especially if it is a long-term illness — in a positive, realistic, understanding manner. Then there is the overprotected child who suddenly complains of pain when the parent is present. The head nurse patiently encourages the child, in the absence of visitors, to develop a healthier attitude towards his illness.

Some parents, when leaving, unconsciously desire tears just to let them know how much their child is missing his home. This is sheer selfishness. The head nurse should endeavor to make them understand the effect of such behavior. She will have accomplished a great deal if she can make the parents understand the folly of this attitude.

The extremely nervous parents present a problem because their nervousness is communicated to the child. Continual reassurance and understanding on the part of the nursing personnel will do much to create stable and mature attitudes in both parents and child.

Visiting Hours

What kind and how many visitors should be allowed to visit the sick child? The patient requires a quiet and restful environment and too many visitors excite and fatigue him. It is usually safe to recommend that only parents or, in their absence, guardians be allowed. If the patient is in a private room, his mother rooming with him, one or two other visitors could be permitted during visiting hours. As a general rule, the child of six and over should have the parents' visit daily.

Visiting hours must be convenient to either the father or mother. They should be fixed by regulation so that they will not conflict with the nursing care and treatment hours. If both parents are working, a late afternoon half-hour of visiting would be advisable; otherwise, the regular early afternoon hours of 2:30-3:30 p.m. are best. Evening hours are not recommended in a pediatric department as they are not beneficial to the child and are a hindrance to good nursing care. Of course if a child is dangerously ill, parents should be given liberty to come at will.

Other Visitors

Keeping in mind the importance of the child's welfare, other visitors are occasionally allowed. Boys' and girls' clubs or selected schoolmates are sometimes permitted to visit in order to distribute comics, scrapbooks, and toys. This form of visiting has proved helpful to the chronically ill child who remains in the hospital for a long time. It should be an exception and needs proper safeguards. Children usually are not allowed to visit in a pediatric department because of the danger of cross-infection from upper respiratory or communicable diseases. Healthy children are also boisterous and noisy and would create an additional responsibility of supervision for the busy head nurse.

Miss Rand in her textbook shows keen discernment when she warns the nurse against making indiscriminate remarks at the bedside of the patient when showing hospital guests around the department. She says:

> There are other visitors who come to the hospital, people with a professional or human interest and they are frequently taken through the wards by a nurse. It is very easy to drop into the habit of talking about the patient at his bedside and perhaps holding forth at length as to the special interest of that particular case. Children are human beings before they are "cases" and, if the illness is to be discussed, the child should be included in some way in the discussion or the discussion should not take place at the bedside. If he is well adjusted to his condition, he can help the nurse in telling the visitor about his experience and so become a part of the little group.

Rehabilitation

Nurses should constantly have in mind, not only the recovery of the child from his present illness, but also

his rehabilitation and the maintenance of his health in the future. The visits provide an opportunity to teach the parent much that will contribute toward the above objective. For instance, in the case of an infant or child who is a feeding problem, the mother could be shown the normal diet and given an opportunity to observe the nurse while she feeds the child. A few days later she might be allowed to feed her baby under the supervision of a nurse. This would give her more self-reliance.

It is very important for the nurse to make such a mother understand, especially if she be the nervous type, that calmness and self-confidence are qualities for her to acquire. The old saying, "Like mother, like child" holds true in child training.

Another occasion when a mother should be carefully taught is in the care of the diabetic child. During the visiting hour the head nurse could give very practical and instructive talks to the parent explaining the condition, the diet and insulin injection. After a few days of such discussions, the mother could come to the ward at the time when insulin is being given. The nurse could explain in simple language the technique of sterilizing the syringe and needle and the preparation and injection of insulin. The mother could prepare and give the insulin under close supervision. She should do so for several days before taking her child home. During this time the simple signs and symptoms of insulin shock or diabetic coma and the precautionary measures to be taken could be explained.

Conclusions

Visiting by the parents definitely favors the recovery of a child despite the fact that they may add to the burden of the staff. Untiring patience, firmness, extreme kindness and understanding of both staff and parents are essential. The maintenance of the child's health and life is so definitely worthwhile. Let us consider him at all times as an individual and administer to his social, spiritual, psychological and physical needs, bearing in mind the words of our Lord: "Whatever you do unto these the least of my brethren, I will consider it as done unto me."

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Safety Training

Safety training for children is paying dividends. Ten years ago, 22 out of every 100 victims killed in traffic accidents in Ontario were children of 14 years and under; in 1952, the ratio had dropped to 15 out of very 100 for children in this age group.

In 1943, there were 75 children in the 5-to-14 age group killed, the total deaths of all ages being 549. Last year, there were 78 children in this age group killed, the total deaths for all ages being 1,010.

Everybody wants to keep children and teen-agers out of accidents. It can be done by more and more safety education and training. For this, the cooperation of all is vital. Here are some safety suggestions to be kept in mind all the time:

Never send children on hurried errands in busy areas.

After dark, if children have to be out, make sure they wear or carry something light in color so that drivers can see them.

See that children leave home in plenty of time to get to school without hurrying.

Set a good example. Be a safe walker, and a safe driver yourself.

—*Ontario Govt. Bulletin*

Aux Infirmières Canadiennes-Françaises

Préparation de l'Etudiante-Infirmière

SOEUR ST-AUGUSTIN, O.S.A.

CETTE tâche de préparer des infirmières dignes de leur mission de demain, c'est à vous, directrices des écoles, c'est à nous, institutrices, qu'elle est confiée.

La société nous prête confiance, se reposant sur nous pour la formation d'infirmières idéales. Ce devoir n'est pas si facile, convenons-en, il ne se fait pas au petit bonheur. Tout ce qui est grand présente des difficultés, mais n'allons pas reculer, sachons les affronter même si elles sont plus nombreuses que jamais.

Nous avons un rôle d'éducatrice à jouer auprès de nos étudiantes. Elles ont les yeux rivés sur nous; il nous faut être à la hauteur de notre mission. On n'en devient pas tailleur du jour au lendemain, encore moins, bonne directrice, officière ou institutrice, sans une préparation adéquate et prolongée, sans les qualifications requises et sans les qualités du coeur et de l'esprit.

Notre élève n'est pas parfaite, mais de nous, elle exige beaucoup, avec raison sans doute. Elle est sûre de trouver chez nous une tenue digne, une physionomie accueillante, un esprit ouvert. Si nous manquons de force morale, de prudence, de justice, elle tend à s'éloigner de nous, à perdre confiance. La dignité professionnelle, la fermeté, la maîtrise de soi-même équilibrée par un jugement droit, voilà ce qui l'aidera à devenir une personnalité.

A l'hôpital, des services bien organisés, pourvus de tout le matériel nécessaire au soin et au confort des malades, un enseignement clinique qui, en complétant la théorie, aide à mieux comprendre le malade pour le mieux soigner, tout cela facilitera la formation de l'étudiante pour sa mission de demain.

Une fois les graduations passées, les diplômes encadrés, à quoi serviront ces honneurs, que donnera à l'humanité souffrante cette gloire d'un jour, si notre nouvelle diplômée, devant se guider elle-même aujourd'hui, est incapable de prendre une initiative, d'organiser son travail, de saisir le concret d'une situation, de faire du bien à ce pauvre patient qui se confie à ses soins? S'il en était ainsi de nos infirmières, disons-le tout bas, ce serait bien là un peu de notre faute . . . surtout, si nous avons eu le malheur d'appuyer plus sur le côté théorique que pratique. La science pratique prime dans nos hôpitaux; elle est à l'honneur en respectant cette belle philosophie de l'école qui veut que nous formions *toute l'élève* pour prendre soin de *tout le malade*.

La pédagogie ne repose-t-elle pas sur une philosophie de l'homme et de la vie? Dans une profession comme la nôtre, qui agit sur la personne humaine, ce n'est pas la technicienne seulement qui exerce son action mais l'être tout entier intervient dans le service de son semblable. Aussi, l'infirmière ne fera-t-elle du bien qu'en autant que son action sera basée sur la compréhension et la compassion.

Cela dit, abordons immédiatement le côté pratique; je m'en voudrais de mépriser la théorie qui est un guide nécessaire à l'exercice de tout art. La science, mais une science pratique est indispensable si l'on veut éviter des erreurs graves dues au manque de connaissances professionnelles.

Permettez-moi de concrétiser ce qui va suivre. Deux jeunes filles, Gertrude et Virginie, s'amènent au parloir de la directrice de l'école. La directrice les

Soeur St-Augustin est institutrice responsable du programme d'études, Ecole des Infirmières, Hôtel-Dieu St-Vallier, Chicoutimi, Qué.

reçoit donc cordialement. Ces deux jeunes filles, rayonnantes de santé, distinguées, polies, se présentent très bien. Elles ont toutes les qualifications morales et académiques tellement nécessaires au cours d'infirmière. Après plusieurs entrevues qui permettent aux aspirantes de se renseigner sur la nature de leur nouvelle vie, la directrice est mise au courant du motif qui leur fait choisir la vocation d'infirmière. Enfin, les formalités d'usage remplies, le bureau de direction de l'école admet Gertrude et Virginie au nombre des étudiantes. L'entrée aura lieu dans deux mois; un beau groupe s'annonce, formé de sujets choisis.

A l'école, tout est en branle pour recevoir la nouvelle recrue. La directrice, les assistantes, les institutrices et toutes les élèves se sont donné la main pour égayer les nouvelles venues, au nombre desquelles sont Gertrude et Virginie. Veillée en famille, chant, musique, jeux, collation, tout a été prévu pour tromper les heures sombres du premier soir et diminuer l'ennui du cher "chez nous." Nous le savons bien, c'est une adaptation pour chacune. Quitter le foyer paternel pour une période assez longue, s'habituer à un milieu, à un règlement nouveau, à des figures inconnues; vivre, pour ainsi dire, en communauté avec toutes ces compagnes de familles différentes, quelle transplantation d'importance!

Pour initier les nouvelles probationistes à l'ordre disciplinaire de l'école, des services hospitaliers, pour développer en même temps l'esprit de famille parmi les groupes, chacune a sa marraine, choisie parmi les anciennes et les moyennes. Le premier contact avec l'hôpital où elles viennent généreusement apprendre à soulager la douleur, la directrice le facilitera en les accompagnant elle-même pour la visite des départements.

Quelques jours passent et tout va bien; un oeil ou deux se sont mouillés mais le coeur maternel et habitué de la directrice a vite trouvé le moyen de tarir les larmes et de faire renaître la joie. Son bienveillant sourire rassure ses élèves. On ne conçoit pas, il me semble, une directrice dure et toujours armée de la férule! On la connaît non pas absolue mais ferme, surtout tendre et pleine d'affection. Qu'elle doive exercer une certaine surveillance, c'est indiscutable, mais *surveiller* — c'est veiller sur quelqu'un pour éloigner de lui ce qui pourrait lui nuire; c'est un acte d'affection et non d'espionnage. Comme c'est gentil de savoir surveiller sans qu'il paraisse que l'on surveille. Les contacts avec l'autorité sont d'autant plus bienveillants et efficaces que l'étudiante trouvera en la personne de sa directrice plus de confiance et de compréhensive bonté.

Les classes sont commencées depuis quelques jours. La directrice des études et les institutrices, infirmières professionnelles et éducatrices de choix, possèdent sans doute des valeurs intellectuelles et morales qui imposent le respect et signent une personnalité transcendante. Elles sont préparées pour aider les étudiantes à maîtriser l'art du soin des malades. En collaboration avec la directrice, elles ont tracé un programme clair, défini, pratique; celui-ci sera envisagé pédagogiquement comme moyen et non comme fin, il en sera ainsi des méthodes d'enseignement.

Le programme, répondant au besoin des étudiantes, ne contient que les connaissances jugées nécessaires; pas de longues théories, pas d'érudition inutile. Nous formons des infirmières et non des médecins. Le programme de l'enseignement clinique a été également préparé par la directrice de l'école en collaboration avec les officières des départements de l'hôpital. Il y a évidemment bonne entente entre l'école et l'hôpital et c'est déjà promesse de succès.

Chez toutes ces éducatrices, une bonne discipline maintenue par une autorité humble et douce, est indispensable; l'autorité qui sait respecter la liberté des élèves, les amène à vouloir faire ce qu'elles doivent faire, sans violence ni contrainte. "L'autorité du maître et la liberté de l'élève sont les deux plus grands ressorts humains de l'éducation," a dit Roland Vinette. La discipline dans nos écoles vise essentiellement la formation morale, individuelle et sociale des infirmières. L'éducatrice veut donc former des infirmières capa-

bles de se conduire dans la vie.

Revenons à Gertrude et Virginie. Elles suivent, avec les étudiantes de leur groupe, les classes que l'institutrice prépare avec attention. L'enseignement de celle-ci est vivant, concret, intéressant; moins livresque que pratique, elle se garde bien d'endormir son auditoire. L'instruction ne passe pas de son livre à celui de l'élève mais de son intelligence à celle de son élève.

L'institutrice parle à son auditoire et le fait parler. Elle est intéressante: elle agit sur sa classe dans la mesure de la richesse de son être. Vraiment convaincue de son enseignement, elle s'exprime dans un tel langage que toute son âme s'y révèle; ses gestes mêmes sont éloquents et entraînants. Ecoutons Monseigneur E. Dévaud: "Le vrai maître est celui qui est capable non seulement d'enseigner avec compétence mais encore de conduire, d'animer, d'entraîner." Il ajoute: "Il exerce son action, à peine par ce qu'il *dit*, bien peu par ce qu'il *fait*, surtout par ce qu'il *est*."

Basant son enseignement sur des principes solides, des méthodes simples et pratiques (cours, questionnaires, recherches, démonstrations, films éducatifs, expériences de laboratoire, symposiums, cercles d'études, conférences données de temps en temps par les étudiantes), l'institutrice réussit mieux à capter l'esprit de son auditoire parce qu'elle s'adresse, à la fois, aux sens et à l'intelligence de ses élèves. Nous connaissons cette vérité psychologique: "Rien n'entre dans l'intelligence sans le concours des sens."

Educatrice et hospitalière dans la force de l'âme, celle qui enseigne a toujours présent à l'esprit le principe du soin des malades, quelle que soit la matière enseignée. De plus, considérant tous les aspects du nursing, elle fait avec ses élèves l'étude psychologique de la personne humaine, leur parlant du mécanisme psychique qui intervient chez les malades, des facilités de compréhension, de la manière d'apporter quelque soulagement physique, moral et religieux.

Elle leur a recommandé la discrétion, qualité indispensable. Notre profession ne doit souffrir aucune infraction à ce sujet; dès le début de ses études l'étudiante doit agir comme ayant déjà prononcé le secret professionel. Toutes ont enregistré dans leur mémoire les précieux conseils. Et voilà qu'elles débutent par une heure de pratique par jour dans les différents départements.

Gertrude et Virginie iront dans un service de médecine. Deux excellentes infirmières leur font le plus cordial accueil; elles les présentent aux autres étudiantes, au personnel du département, les orientent dans le nouvel office et les confient à une infirmière. Cette dernière se charge consciencieusement de les initier au soin des malades, leur indiquant les meilleures méthodes dans l'organisation de leur travail, de leur enseigner délicatement la manière de traiter avec les médecins, les malades, et les visiteurs.

Le service des malades étant organisé en équipes, elles ont l'avantage d'apprendre plus facilement et plus rapidement les différentes façons de prodiguer leurs soins. L'ordre régnant, on s'entend mieux et on travaille plus paisiblement. Gertrude et Virginie sont donc soutenues et bien guidées dans leur profession, depuis les directrices très compréhensives jusqu'aux sous-officières et consoeurs plus avancées qui toutes leur prêtent main-forte.

Malheureusement, les deux élèves n'ont pas le même idéal. Virginie, esprit surtout spéculatif, aime bien orner sa mémoire de connaissances nouvelles, à paraître savante, à conserver le maximum des points aux examens mais ne semble pas saisir la chose capitale et pratique, le but précis de ses études: *le bien du malade.*

Contrairement à Gertrude qui, chaque matin et plusieurs fois par jour, vient saluer le malade avec un bon sourire, Virginie n'ira répondre qu'au troisième son de la cloche tout simplement pour ne pas l'entendre une quatrième fois. Elle n'est pas semeuse de sourires et l'esprit d'observation chez elle est du domaine de la théorie.

Vous vous demandez ce qu'est devenue Gertrude? Elle a persévéré, ayant bien utilisé son temps de probation, elle a su observer et se laisser guider. Des difficultés, n'en-a-t-elle pas rencontrées! Des maladresses, elle en a com-

mises, elle aussi! Mais Gertrude, toujours au devoir, se reprenait et s'améliorait graduellement. Elle n'a travaillé que quelques heures par jour au début. C'est que la directrice a tracé un programme de santé pour ménager le bien-être des élèves et maintenir un bon équilibre qui leur permet de servir les malades plus allègrement. Ainsi les probationistes commencent doucement pour ne donner que quatre heures de travail au quatrième mois. Durant les années qui suivent, elles assument la journée de huit heures, les 50 minutes du cours théorique comprises.

Après la collation des diplômes, Gertrude prend un repos de quelques semaines et revient se dévouer dans sa belle mission. Suivons-la, si vous voulez, maintenant qu'elle est rendue à ce demain pour lequel elle s'est si bien préparé.

Gertrude considère comme des commandements ses devoirs de justice et d'obéissance envers les médecins: toutes leurs ordonnances sont remplies à la lettre et sans délai. Elle ne parle d'eux qu'en bien à leurs patients et inspire confiance en eux. Elle tient exactement le dossier qui renseigne le médecin et lui facilite le diagnostic. Si une urgence lui demande de sacrifier quelques instants de repos, elle les donne avec joie, semblable à cette élève qui, demandée un jour au parloir, préfère demeurer auprès d'une patiente qui réclame sa présence absolument.

Chef d'équipe, Gertrude enseigne, aide ses compagnes, se met à la portée de chaque catégorie d'élèves et ne leur demande que des travaux proportionnés à leurs capacités. Son officière lui confie des responsabilités et se repose sur elle avec certitude. Elle accepte aimablement les petites suggestions pratiques imaginées par Gertrude pour contribuer au bien général.

Si Gertrude et beaucoup d'autres sont des modèles d'infirmières compétentes, si elles ont du succès dans leur carrière, si elles sont une aide précieuse à la société, c'est qu'elles ont travaillé, elles ont peiné, elles ont prié, elles ont souvent lancé un regard confiant vers le ciel. Ajoutons qu'elles ont été préparées par de vraies éducatrices dont le but est d'élever la personnalité humaine à la hauteur de sa profession.

Donnons, en terminant, la part si importante des officières; en rapprochant l'école de l'hôpital et l'hôpital de l'école, elles ont favorisé l'intégration entre la théorie et la pratique. En plus des buts éducatifs et professionnels, elles ont réalisé le but religieux en préparant des infirmières chrétiennes qui aiment le malade et, qu'est-ce donc aimer, si ce n'est sortir de soi pour aller aux autres! Elles ont formé des infirmières compatissantes, capables de s'attendrir, de s'incliner charitablement sur le souffrant et l'infortuné.

Gardons de bonnes relations avec nos anciennes élèves; rendons-leur service au besoin; qu'elles se sentent toujours de la famille et accueillons-les maternellement dans l'institution à chaque réunion de l'amicale.

Si quelques-unes demeurent en service à notre hôpital, ayons soin de les faire travailler "avec nous" et non "pour nous." Pour ce faire, considérons-les comme nos coopératrices, nos amies, nos soeurs. Prenons soin de leur santé; mettons-les au courant de nos activités; faisons-leur confiance en leur donnant des responsabilités; encourageons les plus dévouées par des promotions de temps en temps.

Why Move the Flowers?

Many people remove plants and flowers from a sickroom before the patient retires for the night. Why? The practice, in many instances, stems from the once-widespread belief that plants, in breathing, compete with humans for the vital components of the air. This theory was disproved long ago.

Flowers, of course, should be removed if they are strong-smelling and might in any way disturb the patient. But apart from that the only good reason for removing them from a sickroom is for the sake of the flowers, not the patient. By storing them in a cool place, they keep sweet-smelling and fresh far longer.

—*SIS: Medical Features*

News and Echoes

from

Your NATIONAL OFFICE

C.N.A. Executive Meeting

At the Executive meeting of the C.N.A. held in Montreal the end of January, the various national committee chairmen were giving a final look to the activities of the Biennium. Reports were well on their way to completion and plans being finalized for their printing.

In order that the deliberations of the General Meeting might be incorporated into the reports for publication in *The Canadian Nurse,* it was decided to obtain preliminary reports and have them printed in "reprint" form for distribution prior to the General Meeting in June. After changes necessitated by discussion and conclusions at the General Meeting have been incorporated by the committee chairmen, the reports are to appear in their finalized form in the September issue of *The Canadian Nurse.* This is a departure from previous procedure but it was felt that because many members refer repeatedly to these reports in *The Canadian Nurse* it was advisable to have the corrected version appear. Copies of the preliminary reports will be available through provincial associations and from National Office upon request.

Convention Travel

All members will be aware by now that special trains will start from Toronto, Montreal and Vancouver to allow them to arrive in Banff, Sunday, June 6. Even if you do not board a special train you may take advantage of convention rates. From National Office special pink identification forms are being sent out to all who have pre-registered since the beginning of 1954, and will be sent out upon request to those who pre-registered previously. If your plans are still indefinite and you will not be sure whether you can attend until you actually arrive in Banff, we will still be glad to send you one of these forms. It is important to remember that you cannot obtain convention rates — either on the special train or otherwise — without this identification certificate!

Program for Banff

The C.N.A. Program Committee had its final meeting the day before the last Executive meeting, at which time reports of action taken by the various sub-committees were carefully reviewed. The chairmen of national committees, who were assisting with different parts of the program, were invited to be present and gave details of their particular projects.

Printed elsewhere in this issue you will find the tentative program and will see that the hard work of the past months has produced what cannot help but be a blueprint for five days of interest-packed activity. Two guiding principles have been followed by the committee and its chairman, our president. One is to show what we nurses and our institutions or agencies in Canada have been doing. The other is to attempt to illustrate the effect of the proposed changes in national committee structure and function. The planning has been done, the participants have been invited, now it is up to those who must ascend the platform at Banff and really make the program work.

From where the committee sat around the conference table, it appeared that the C.N.A. had been highly complimented this year on the calibre of participants who had accepted our invitations. But we cannot forget that it takes more than the effort of those on the platform to make a successful convention. The program has been printed in this *Journal* so that all our members may have an apportunity to think over the various items to be presented and to come prepared to

make a contribution to the discussions. This is especially essential for this — the 27th Biennial Meeting. Many changes in the By-laws have been proposed and will be presented in the report of the Committee on Constitution, By-laws and Legislation. Do *you* know what the implications of these proposed changes are? In the report, which you may obtain from your provincial office or from National Office, will be listed the present By-laws and the suggested changes. Study them carefully and come prepared to support your voting delegates or to express your own views.

Nouvelles et Echos

de

Votre SECRETARIAT NATIONAL

LE COMITE DE REGIE, A.I.C.

Lors de la dernière réunion du Comité de Régie de l'Association des Infirmières Canadiennes à la fin de janvier, les convocatrices des divers comités nationaux mirent la dernière main aux préparatifs du Congrès Biennal. Les rapports furent complétés et prêts à être imprimés.

Un changement important a été décidé concernant les rapports — ceux-ci tels que présentés seront imprimés et distribués avant le Congrès général de juin. Une fois ces rapports discutés et les changements proposés adoptés, le rapport final sera publié dans *L'Infirmière canadienne* du mois de septembre.

Cette nouvelle mesure a été prise parce que très souvent les membres de l'A.I.C. consultent les rapports publiés dans la revue; il semble donc à propos de ne publier que les rapports finals. Pour obtenir les rapports préliminaires, l'on a qu'à s'adresser aux associations provinciales ou au Secrétariat National.

LE VOYAGE DU CONGRES

Tous les membres sont au courant que des trains spéciaux partiront de Montréal, Toronto et Vancouver et arriveront à Banff, dimanche le six juin. Même si vous ne partez pas par ces trains vous pouvez bénéficier du prix spécial offert aux congressistes. A cette fin une carte d'identification, de couleur rose, a été envoyée à tous les membres déjà inscrits depuis janvier, 1954, et sera envoyée à toutes celles qui en feront la demande avant le Congrès. Si vous êtes indécise à propos de ce voyage et doutez qu'il vous soit possible de vous rendre à Banff, nous vous enverrons tout de même cette carte d'identité. Elle est indispensable pour obtenir un rabais sur le prix du voyage.

LE PROGRAMME DU CONGRES

Le Comité du Programme a revisé avec soin tous les projets des divers sous-comités et la convocatrice a présenté au Comité Exécutif le programme en détails.

Vous verrez un peu plus loin dans cette revue le programme proposé. Les activités de ces cinq jours peuvent vous faire juger de la somme de travail qu'a exigée durant des mois la préparation de ce Congrès. La convocatrice du Comité du Programme, la présidente de l'A.I.C., a suivi deux principes dans la préparation du Congrès: le premier est de montrer ce que nous avons accompli, nous les infirmières, dans les institutions et dans les agences de santé et de bien-être; le deuxième est d'essayer d'illustrer les changements proposés dans la structure de l'A.I.C. et leurs effets sur les comités nationaux. Maintenant tout est prêt — les participants aux Congrès ont été invités, il ne leur reste une fois sur le plateau qu'à exécuter le programme.

Il semble que le comité doit être complimenté sur le choix des participants, leur renommée nous fait honneur. Le succès d'un congrès ne dépend pas uniquement des efforts de ceux qui sont au programme. La participation active des membres est aussi un facteur essentiel. Le programme a été imprimé dans cette revue, afin que chacune connaisse à l'avance ce qui sera présenté et vienne au Congrès préparée à prendre part aux discussions. Durant ce 27e Congrès bien des changements aux règlements ont été proposés et d'autres le seront par le Comité de Législation, il est donc important d'être bien renseigné et préparé à prendre part aux discussions. Etes-vous au courant des conséquences qu'amèneront ces changements? Dans le rapport du Comité de Législation, que vous pouvez vous procurer au Secréta-

riat National, vous trouverez les règlements actuels et les changements proposés. Etudiez-les avec soin et soyez prêtes à supporter le vote de vos déléguées.

Tentative Program for 27th Biennial Meeting of the C.N.A.

Banff Springs Hotel, Banff, Alberta

JUNE 7-11, 1954

Sunday — June 6

Meeting of Executive Committee, C.N.A.

Monday — June 7

MORNING

Miss Helen G. McArthur, President of the C.N.A., presiding

Invocation — Rev. Gordon A. Peddie, B.A.

Addresses of Welcome and Greetings

Roll Call of Federated Associations and the reception of the Association of Registered Nurses of Newfoundland into the C.N.A.

Announcements

Report of the Committee on Program — Miss Helen G. McArthur

Report of the Committee on Arrangements — Miss Frances Ferguson

Appointment of Resolutions Committee

Instructions to Voting Delegates

Opening Address — The Honorable Paul Martin, Minister of National Health and Welfare

Report of Nominating Committee — Miss M. I. Walker

AFTERNOON

Structure Study:

Report of the Committee on Constitution, By-laws and Legislation — Miss Rae Chittick

EVENING

Chuckwagon Dinner, Banff Springs Hotel

Tuesday — June 8

MORNING

Finance:

Report of the General Secretary — Miss M. P. Stiver

Report of the Treasurer — Miss M. P. Stiver

Report of the Committee on Finance — Miss G. Sharpe

Report of the Loan and Bursary Committee — Miss H. Lamont

Introduction to "Trading Post"

Introduction of representatives of Commercial Exhibitors

AFTERNOON

Free for group and individual activities. Tours, golf, riding and other types of recreation are being arranged.

EVENING

Films at Banff Springs Hotel

Wednesday — June 9

MORNING

Nursing Service:

Reports of Committees on:

Code of Ethics — Miss E. Logan
Health Insurance — Miss E. Robertson
Institutional Nursing — Miss M. Macfarland
Public Health — Miss H. Carpenter
Private Nursing — Mrs. E. Brackenridge

Dramatic Presentation "Let's Work Together" — the teamwork principle and nursing services.

AFTERNOON

Personnel Policies and Problems:

Report of the Committee on Employment Relations — Miss G. Purcell
Panel Discussion:
Chairman — Miss G. Purcell
Panel — Dr. A. L. Swanson, Executive Secretary of Canadian Hospital Association
Miss L. Sutherland, Representative of Canada Life Assurance Co.
Miss E. Hood, Director of Personnel Services, Registered Nurses' Association of British Columbia
Miss A. Smith, Chief of Nursing Service, Indian Health Services, Department of National Health and Welfare
Miss M. Myers, Superintendent of Nurses, Tuberculosis Hospital, Saint John, N.B.

EVENING

6:00 p.m. — Student Nurses' Buffet Supper
8:30 p.m. — Fashion Show of Nurses' Uniforms

Thursday — June 10

MORNING

Nursing Education:

Report of the Committee on Educational Policy — Miss E. Mallory
Symposium — Dr. C. A. Roberts, Director, Division of Mental Health, Department of National Health and Welfare — "Mental Health Problems in Canada"
Other members of the symposium will be C.N.A. members who are engaged in the education of nursing personnel for the mentally ill.

AFTERNOON

Free for group and individual activities
3:00 p.m. — Meeting of Nursing Sisters' Association of Canada — Mount Rundle Room, Banff Springs Hotel

EVENING

6:30 p.m. — Reception and Banquet — Nursing Sisters' Association of Canada — Mount Norquay Lodge

Friday — June 11

MORNING

Communications:

Reports:
Editor and Business Manager, *The Canadian Nurse* — Miss M. E. Kerr
Editorial Board, *The Canadian Nurse* — Miss I. Black
Committee on Public Relations — Miss M. I. Walker
Committee on Student Nurse Activities — Miss E. Farquharson

Panel — The C.N.A. and Public Relations:
Chairman — Miss M. I. Walker
Miss M. E. Kerr, Editor, *The Canadian Nurse*
Miss E. Farquharson, Chairman, Committee on Student Nurse Activities
Mr. R. McLean, Public Relations Officer, Department of Economic Affairs, Alberta Government
Miss E. Pepper, Nursing Consultant, Health Planning Group, Civil Defence, Department of National Health and Welfare
Miss Eileen Greany, Student Nurse, Edmonton General Hospital.

BIENNIAL MEETING PROGRAM

AFTERNOON

Final Voting
Structure Study — Final discussion and Voting
Unfinished business
New business
Report of Resolutions Committee
Closing Address — Dr. Malcolm Taylor, Department of Political Economy, University of Toronto

EVENING

Mary Agnes Snively Memorial Lecture "Forty Minutes" — Prof. F. M. Salter, Department of English, University of Alberta

Installation of Officers — Ballroom, Banff Springs Hotel

Saturday — June 12

Meeting of Executive Committee, C.N.A.

1954 Biennial Reports

SINCE 1948 ALL OF THE REPORTS that are to be presented at the Biennial Convention of the Canadian Nurses' Association have been published ahead of time in the May issue of *The Canadian Nurse*. At its meeting the end of January, the C.N.A. Executive Committee decided to experiment with a new pattern for the distribution of all these reports. They are to be made available in "tumble" booklet form — one way up will be the English version; turn the whole booklet over and there are the reports in French.

Plenty of copies of these booklets will be available early in May. Copies will be provided through the provincial nurses' associations for all of their official delegates. Individual nurses may secure copies by completing the form below and mailing it to the Canadian Nurses' Association. Whether you are going to the convention or not, you will want to know what is going on.

The September, 1954, issue will reprint the complete reports indicating the action taken on the various recommendations.

Send for your copy early.

1954 BIENNIAL REPORTS

Nurses wishing to receive an advance copy of the reports that are to be presented at the Biennial Convention, Banff, June 7-11, 1954, may complete this coupon.

Mail it to:—

THE CANADIAN NURSES' ASSOCIATION
1411 CRESCENT STREET
MONTREAL 25, QUEBEC.

NAME .....

STREET .....

City ..... **Zone No.** ..... **Prov.** .....

Number of copies desired .....

Nomination Ticket, 1954-56

The following is the Nomination Ticket, 1954-56, for the officers, chairmen, regional representatives of the nursing sisterhoods, and Nominating Committee of the Canadian Nurses' Association. The names are listed in alphabetical order, where multiple nominations occur. The present position of each nominee is indicated:

President: Miss Gladys Sharpe, director of nursing, Western Hospital, Toronto, Ont.

First Vice-President: Miss Trenna Hunter, director of nursing, Metropolitan Health Committee, Vancouver, B.C.; Miss Evelyn Mallory, director, School of Nursing, University of British Columbia, Vancouver.

Second Vice-President: Miss Alice Girard, director, School of Nursing, University of Montreal, Montreal, Que.; Miss Agnes Macleod, director of nursing, Treatment Services, Department of Veterans Affairs, Ottawa, Ont.

Third Vice-President: Miss Jean Clark, supervisor of education, University School of Nursing, Edmonton, Alta.; Miss Muriel Hunter, New Brunswick Dept. of Health, Fredericton.

Chairman, Committee on Institutional Nursing: Miss Gertrude Hall, director of nursing, General Hospital, Calgary, Alta.; Miss Edith Young, director of nursing, Civic Hospital, Ottawa, Ont.

Chairman, Committee on Private Nursing: Miss Mary Franko, 9013 - 106th St., Edmonton, Alta.

Chairman, Committee on Public Health Nursing: Miss Katherine MacLaggan, Teachers College, Fredericton, N.B.; Miss Ruth Morrison, assistant professor, School of Nursing, University of British Columbia, Vancouver; (Withdrawn) Miss Lois Smith, field supervisor, Public Health Nursing Service, New Brunswick Dept. of Health, Fredericton.

Regional Representatives of the Nursing Sisterhoods:

Maritimes: Rev. Sister Helen Marie, director of nursing, St. Joseph's Hospital, Saint John, N.B.; Rev. Sister Mary of Calvary, director of nursing service, St. Joseph's Hospital, Glace Bay, N.S.

Quebec: Rev. Sister Denise Lefebvre, director of nursing education, Institut Marguerite d'Youville, Montreal, Que.; Rev. Sister St. Ferdinand, director of nursing, St. Michel Archange Hospital, Mastai, Que.

Ontario: Rev. Sister Aileen Byrnes, director of nursing, Hôtel-Dieu Hospital, Kingston, Ont.; Rev. Sister Mary Frances de Sales, St. Michael's Hospital, Toronto.

Manitoba-Saskatchewan: Rev. Sister Adèle Levasseur, educational director, Grey Nuns' Hospital, Regina, Sask.

Alberta-British Columbia: Rev. Sister Mary Beatrice, director of nursing, St. Michael's Hospital, Lethbridge, Alta.; Rev. Sister Marie Laramée, director of nursing, General Hospital, Edmonton, Alta.; Rev. Sister Mary Lucita, educational director, St. Joseph's School of Nursing, Victoria, B.C.

Nominating Committee (three to be elected): Miss Eileen Flanagan, nursing supervisor, Montreal Neurological Institute, Que.; Miss Dorothy Gill, supervisor, Psychiatric Dept., Victoria General Hospital, Halifax, N.S.; Rev. Sister Columkille, Notre Dame Hospital, North Battleford, Sask.; Rev. Sister Mary Grace, St. Joseph's Hospital, Guelph, Ont.

The Atom Sterilizes Pork

Ancient religious laws forbidding the eating of pork indicate that trichinosis, the parasitic worm disease transmitted in undercooked pork, was a menace to health even in Biblical days. Since then, although no effective treatment for the disease has been found, we have learned how to protect ourselves. Prolonged storage at low temperatures and proper cooking destroy the trouble-some organisms and make the meat safe for human consumption.

However, considerable numbers of people are still infected each year. Now, experiments indicate that atomic irradiation can probably be used to sterilize pork carcasses. This would make trichinosis organisms harmless and enable pork to be eaten anywhere at any time.—*SIS: Medical Features*

Focus on . . .

A Two-Way Flow

O. Spurgeon English, M.D., believes that the whole question of getting along with the younger generation is an important part of growing older. In an article called "Keep Your Mind Limber," condensed in *Blue Print for Health,* Fall, 1953, he gives pointers on how older people can acquaint themselves with what the generation on the step below them is thinking and doing. Though the article is directed mainly to grandparents and their relationship with children, Dr. English's points can be significant, too, for those of us who find ourselves too often "at sea" when dealing with young children. He says we must set out right now with an *open mind* to establish a two-way flow of ideas between them and ourselves.

A good way of establishing contact with children, or with one child, is by *respectfully* asking their opinion on some matter. Care must be taken then not to tear it down by insisting that it is no good and our own is better. Scan their books and comics to see why they find them so interesting. Don't criticize their reading material unless you have something better and equally enthralling to give them in its place. Ask about their activities, their friends, and their interests, but don't show boredom or impatience with the recital.

Dr. English feels that we should not expect children to treat us with any more deference than we are willing to show them. He emphasizes that the affection of children must be *earned* — it cannot be demanded. We must show real interest in them and their activities before we can expect them to be really interested in us. We cannot expect that either blood ties or a position of authority will carry any real weight if children know that we are mostly concerned with criticizing, pointing out their failures, ignoring their little triumphs and successes, and trying to impress on them that our ideas are better than theirs. This type of person does not gain the spontaneous love of younger persons and will probably live a lonely, fretful old age, left out of the family's activities.

Dr. English reminds us that it is in the short time while children are little that we establish the attitudes towards older people that children will carry all through life and that will be reflected back to us later. It is then, too, that we develop in them the character traits and mental attitudes that can help make life an interesting, exciting adventure, or a limited, unproductive existence.

As children grow older, parents should avoid imposing on them to run errands or do shopping, etc.; or complaining of loneliness so that the children feel duty-bound to provide interest and entertainment, whether they want to or not.

After the children are 21, Dr. English feels that parents should not force advice on them but "show that you trust them to know what is best for themselves and to have sense enough to ask for guidance if they feel they need it."

As a grandparent, Dr. English promises that "you will be faced with the delightful and challenging opportunity of winning the affection and respect of your grandchildren, not on the basis of relationship, but upon your own merits as a human being whose society and companionship is valuable and desirable.

Weight and Electrocardiograms

Writing in the August, 1953, issue of the *American Practitioner,* Dr. Arnold H. Kadish makes some interesting observations about the correlation between changes in body weight and the electrocardiographic pattern. In four recent cases, he noted changes with fluctuations in body weight. In none could the variations be attributed to extraneous factors such as pericarditis, emotion, electrolytic change, toxins, acute infections, etc.

In a case record of a 42-year-old white man who weighed 194 pounds, Dr. Kadish reports that the total picture, including electrocardiogram, was suggestive of myocardial ischemia. In a month, the patient lost

10 pounds on a 1,000-calorie diet. The electrocardiographic pattern then was normal and he was symptomless. Three months later the patient returned with a recurrence of symptoms, having gained nearly 12 pounds. At this time the ECG again reflected his condition and a 1,000-calorie diet and bed rest were prescribed. Within three weeks the ECG returned to a normal pattern and the patient lost 8 pounds. The ECG remained normal for a year and then again reflected a weight gain. A return to the 1,000-calorie regime brought his weight down and subsequent ECG's have been normal. The patient is finally convinced of the wisdom of keeping his weight down.

The second case was that of an overnourished man who came to Dr. Kadish for a general examination. The electrocardiogram revealed typical evidence of left ventricular strain. He was advised to restrain his diet to 1,000 calories but this he refused to do because of the absence of symptoms. Two months later the patient underwent surgery for a benign pyloric ulcer, in the course of which he lost 16 pounds. Examination a month following surgery showed a reversal in the electrocardiographic pattern. In this case, the loss of weight was not deliberate but incidental following partial gastrectomy.

Two other cases are cited which illustrate an alteration of the ECG pattern with fluctuations of body weight. In none of them could extraneous causes be found.

Amyotrophic Sclerosis

The disease from which Lou Gehrig died, amyotrophic lateral sclerosis, was the subject of study on the island of Guam. Participants in the investigation were the United States Public Health Service, the U.S. Navy Bureau of Medicine and Surgery, and the Dept. of Interior.

Amyotrophic lateral sclerosis is a degenerative disease of the nervous system characterized by breakdown of the fatty covering of the nerve fibres of the brain and spinal cord. Multiple sclerosis is another better known condition in the large group of demyelinating diseases. There seem to be two types of the disorder: a slow progressive type primarily paralyzing the muscles of hands and arms; and a more rapidly developing type where shoulders, neck, tongue, lips, palate and pharynx are initially involved and paralyzed. In this bulbar type, death by asphyxia or from aspiration pneumonia usually occurs within two years.

There is no effective treatment for this disease and its cause is unknown. Approximately 1,500 to 2,500 cases occur yearly in the United States. The average case has about three years to live from the time the disease is incurred. Its most frequent occurrence is between the ages of 30 and 35.

According to available statistics this crippling, fatal disease is very prevalent on Guam, so that it was an excellent locale for such a study. The investigation of hereditary factors in the development of the disease were facilitated also because of the relatively fixed population on the island. Evidence in the literature indicates that the disease, *lytico* as it is known to the natives, has been prevalent there for generations.

The specific problems studied were: Is amyotrophic lateral sclerosis — a.l.s. — as prevalent on Guam as believed? Is it exactly similar to the disease as known elsewhere? What is the cause — is it genetic, traumatic, infectious, nutritional, or other? To obtain the data, the research team examined other groups as well as those suffering from a.l.s. It was thought that examination of the siblings of patients might reveal why only some of the members of a family are affected; examination of a random group might help to isolate the special conditions responsible for the disease; and study of natives on a neighboring island would help determine if a.l.s. is a problem on Guam alone or for other areas in the Marianas.

Most persons who reach age 65 can expect to live for a considerable number of additional years. On the basis of the current mortality experience, more than one-half of the men who attain that age will survive another 12 years and one-fifth for 20 years. Similarly, one-half of the women who reach age 65 will live to age 80 and about one-fifth will survive to celebrate their 88th birthday.

* * *

After all is said and done, it usually works out that more was said than done.

The biggest room in the world is the room for improvement.

Student Nurses

Rickets

BETTY HUTCHESON, KATHRYN GORDON *and* FLORA MORRISON

RICKETS IS DUE to a deficiency of vitamin D. Insufficient sunlight and inadequate vitamin D intake are the chief causes. Most foods included in the diet of an infant do not contain the recommended 400 I.U. per day so it is necessary to give a vitamin D supplement, such as fish liver oil. Small children frequently spend a large part of their early years indoors so do not get adequate sunshine, especially in cold northern areas.

Parents often discontinue vitamin preparations at the end of the first year. This is an unfortunate practice as moderate to severe rickets tends to develop at the end of the first year and early in the second. Very rapid growth of the long bones occurs at this time, increasing the need for adequate vitamin D intake. Crowded living conditions, poor dietary habits, low economic status, insufficient medical supervision, and poor health education play an important role in the development of rickets.

The chief pathologic changes are in the bones. In normal bone growth, osteoid tissue, produced from the bone marrow, becomes mineralized to form bone. In rickets, the cartilage and osteoid tissue continue to be formed but no mineralization or calcification takes place. The result is a bone that bends very easily. Masses of excess cartilage and osteoid tissue form a bulge with resulting enlargement of the bones at the cartilage-shaft junction.

In rickets the inorganic phosphorus of the blood is usually reduced to 1.5-3.5 mg./100 cc. (normal 4.5-6.5); the serum calcium frequently is normal (9-11 mg./100 cc.) but may be reduced. Phosphatase, an enzyme active in bone production, is increased in rickets to 20-30 or more units/100 cc. (normal is 5-16 units/100 cc.).

The three authors were senior students in the pediatrics department of University Hospital, Edmonton, Alta., when this study was written.

CLINICAL MANIFESTATIONS

There may be softening of the skull bones and delay of closure of the anterior fontanel (open normally until the child is 18 months of age). The teeth may be delayed in erupting and may have defective enamel. Permanent teeth formed during the ricketic period frequently have defective enamel as well.

In the chest, rounded knobs are formed. These can be felt on the anterior surface of the chest. The name "rachitic rosary" is applied because they feel like the beads of a rosary. The sternum may project forward giving a pigeon-breasted effect. Since the bones are weak, the chest wall may

SAMMY

retract at the sites where the diaphragm tugs with each respiration (Harrison's groove). Kyphosis, scoliosis, or lordosis may occur due to relaxation of the ligaments. Many deformities of the skeleton can occur such as bowlegs, knock-knees, and enlargements of the joints.

Case History

Sammy was admitted to hospital for treatment of rickets which he has had since he was 18 months old. He is now 12 years of age, one of a family of 11 children ranging in age from 4 to 25 years. Sammy's parents own a half section of land in a very poor farming district. This large family lives in a three-room house!

During infancy Sammy was healthy but after he developed rickets his bones grew improperly. He was unable to walk until he was eight years old. He was hospitalized as a baby and again when he was eight, at which times he was given C.L.O. in an effort to curb his disease. At the time of his first discharge, Sammy's parents were advised of the importance of continued vitamin therapy but they did not get any more vitamins after the initial supply had been exhausted. Possibly because the other children were healthy they thought Sammy should progress favorably on the usual diet and routine. Insufficient funds and lack of education were chiefly responsible. In Sam's own words, "We always had plenty of bread, butter and milk to eat but not many fresh fruits and vegetables."

On admission to hospital Sammy's diagnosis was established as "rickets with bony deformities." He weighed 43 pounds.

Laboratory tests indicated a ricketic condition: serum phosphorus 2.6 mg.%; serum calcium 7.5 mg.%; and alkaline phosphatase 40.0 units.

Physical examination revealed many signs and symptoms of rickets. He lacked several teeth but few were defective. Sammy's chest was symmetrical with equal expansion. A rachitic rosary was fairly marked along the costochondral junctions. His pelvis was normal.

The upper extremities were bilaterally symmetrical, the humerus being short with large condyles. The wrists and hands were disproportionately large for the arms. The lower extremities were bilaterally symmetrical with marked anterolateral bowing of the femurs and external rotation of the tibias. There was external flexion of the hip joints. Both knee joints showed laxity with absence of knee jerks. There was full range of flexion. Ankle joints and feet were normal although the feet were disproportionately large for the length of the legs.

Medical and Surgical Treatments

Rickets may be successfully treated with sunlight and ultraviolet irradiation. However the oral administration of vitamin D is far easier and much more rapidly effective. Although there is no standardized dose, 1,500 I.U. daily are generally given for mild cases and 5,000 I.U. per day for severe cases. In these doses there is no danger of toxic effects. Healing begins within a few days although deformities may persist. These deformities are treated by surgery.

Sammy received a daily dose of 5,000 I.U. of a vitamin D preparation, as well as 500 mg. of vitamin C twice daily. To aid in the correction of his severe genu varus deformity, a bilateral osteotomy of both tibia and fibula was performed and a bilateral plaster of paris cast applied. An x-ray was taken two days after the operation through the cast to check the position of the knees. This was found to be satisfactory.

Nursing Care

During the period immediately following application of the cast the circulation in the feet was checked q. 2 h. Careful watch was kept for signs of pressure under the cast. At no time was his circulation impaired nor was any portion of the cast causing pressure areas. The entire cast was trimmed and cuffed with adhesive tape as soon as it was thoroughly dried.

Diet is extremely important in the recovery process. We encouraged Sam to eat high calorie, high protein foods. Many fresh fruits and vegetables were included because roughage is so im-

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portant. Due to his immobility and consequent lack of exercise a careful check was kept on his bowel hygiene. Recording of fluid intake and output was important. He took fluids well so his fluid balance presented no problem. A ricketic child should eat foods containing vitamin D, such as egg yolk, green vegetables, and irradiated milk. Orange juice and ascorbic acid are thought to have anti-ricketic as well as antiscorbutic action.

Sammy needed plenty of fresh air, sunshine, rest, activity, and a wholesome, hygienic daily routine. In our hospital it was difficult to give him adequate fresh air and sunshine. His activity was restricted by his cast.

One very real nursing problem was helping Sam adjust to hospital routine. He was extremely homesick and lonely for many days following admission. All effort to cheer him seemed futile. His dwarf-like, bowlegged appearance was funny to the other children, so Sammy withdrew into himself taking no interest in his surroundings nor the other patients. He conversed little with the nurses and spent the best part of each day crying to himself. Following operation he experienced periods of acute pain and required much analgesia.

After these trying days Sam took a new lease on life. In his cast his deformities were hidden from the other children and by degrees he became a friend to all. He soon craved new interests and a change of scenery. He spent many contented hours on a stretcher which we wheeled to various windows of the ward. He was keenly interested in school work and with some assistance did very well. The nurses encouraged him to knit. This was a brave challenge which our Sammy mastered!

Today Sammy is, perhaps, the most contented and well adjusted youngster on the children's ward. With continued medical treatment and proper care at home following discharge he should recover to the point where he can lead a normal, healthy, and active life though he will always be small for his age and have some bone deformity.

* * *

Food fussiness is never inherited but is often imitated.

Book Reviews

The Anatomy and Physiology of Obstetrics — A Short Textbook for Students and Midwives, by C.W.F. Burnett, M.D. 168 pages. British Book Service (Canada) Ltd., 1068 Broadview Ave., Toronto 6. 1953. Price $3.50.

Reviewed by Margaret G. Russell, Obstetrical Supervisor, St. Joseph's Hospital, London, Ont.

Collectively, the theory subject matters have been condensed in such a manner as to make this book ideal for practical teaching. Interestingly written, it demonstrates a rich store of material for nursing and for understanding the anatomy and physiology of obstetrics. It provides a comprehensive knowledge of the two subjects as they are related to obstetrics rather than anatomy and physiology as a whole. This, in itself, is an attraction not only for the student nurse but may be used to good advantage as a guide for lectures to student nurses and in clinical work.

The book is divided into nine units, each of which is highlighted by numerous diagrams of excellent visual quality. To my knowledge, its contents aim at and approach the requirements of the obstetrical student better than any other book on the market. The author has taken into consideration the need for a simple, yet thorough study of the subject and provides excellent clinical knowledge. An outstanding contribution to the field of anatomy and physiology of obstetrics — an excellent guide in my phase of nursing.

Aids to Theatre Technique, by Marjorie Houghton, S.R.N. 260 pages. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1952. Price $1.15.

Reviewed by Sister Monica Marie, Supervisor, St. Joseph's General Hospital, Port Arthur, Ont.

This is a compact little volume, written with authority and clarity by one whose knowledge of her subject is unquestioned and outstanding.

It truly is, as the sub-title indicates, a complete textbook for the nurse, whether student, graduate, or supervisor. It embraces all that should be known of the

operating theatre as a hospital unit — its functions, its appointments and equipment, and its demands on the nurses who are to be found there in varying capacities.

The volume offers a comprehensive list of surgical operations, with numerous illustrations of instrument lay-outs, each appropriate to the particular operation described. This series of photographs, each unmistakably identifying the instruments on the table, serves quickly to familiarize the student with the names of the instruments associated with any given surgical operation.

The glossaries of surgical instruments and of laboratory technical terms are of their own especial value and interest.

In a book of such uniform excellence throughout, it is difficult to select any one chapter as being outstanding. However, the chapter on the profoundly important subject of sterilization seems to be particularly meritorious. Here, the older and newer methods of sterilization are described and contrasted with admirable effect.

Miss Houghton's textbook cannot be commended too highly. It is a remarkable product of experience and scholarship. No nurse should be without it.

Dermatology — A Textbook for Nurses, by Herbert Rattner, M.D. 270 pages. McAinsh & Co. Ltd., 1251 Yonge St., Toronto 5. 1953. Price $4.25.

Reviewed by Elva Pool, Clinical Instructor, School of Nursing, General Hospital, Vancouver.

The author has succeeded in his purpose of acquainting the reader with the "many unsolved problems in dermatology." A comprehensive picture is given of skin conditions. The material is presented in an interesting fashion with many illustrations — "for diseases of the skin must be seen to be recognized." The book begins with a description of normal skin and a discussion of measures used in its care. The merits of bathing and cosmetics are dealt with here.

The chapter on General Methods of Treating Skin Conditions is a valuable one, including nursing procedures for treatment baths, wet dressings, application of lotions, ointments, and powders. Descriptions and pictures display many functional bandages that are as simple as possible to apply. His preparation for an oatmeal bath is as follows: "Prepare a cheesecloth bag containing one-half to one pound of oatmeal bran. In filling the tub, first allow very hot water to run through this bag and then complete the filling of the tub with water at a suitable temperature. Place the bag in the tub and squeeze it occasionally."

The remainder of the book gives a comprehensive description of the many conditions that may affect the skin. The treatment outlined is based on experienced practice. It is emphasized that all factors that may produce the condition must be considered.

This book would be most valuable for instructors or nurses who specialize in dermatology. The author went beyond the requirement of giving the student "a necessary knowledge of the more common diseases of the skin."

Essentials of Physiological Chemistry, by Arthur K. Anderson. 480 pages. John Wiley & Sons, Inc., 440 Fourth Ave., New York City 16. 4th Ed. 1953. Price $5.00.

Reviewed by Henrietta J. Alderson, School of Nursing, McMaster University, Hamilton.

This book covers in simplified form the broad field of physiological chemistry and is particularly suited to the student with a limited science background. The early chapters discuss in sufficient detail the fundamental concepts relative to biophysical chemistry, carbohydrates, fats, and proteins to enable the student to read with understanding the subsequent material. In this new edition the author has incorporated many advances in biochemistry relative to photosynthesis, enzymes, hormones, chemotherapeutics, and antibiotics but controversial subjects have been kept to a minimum. Many of the chapters have been rewritten, some in greater detail, some with greater emphasis upon physiological reactions, and some with newer structural formulae.

Bibliographies including larger and more detailed texts or well chosen periodical references, sufficient to stimulate the student of wider interests, are given at the chapter endings. This book should be a helpful reference volume for most schools of nursing and, for some collegiate schools, would be an excellent beginning text for undergraduate courses in physiological chemistry.

Textbook of Pharmacology for Nurses, by Margene O. Faddis, R.N., assisted by Joseph M. Hayman, Jr., M.D. 520 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 4th Ed. 1953. Price $4.50.

Reviewed by Fanny Munroe, former Supt. of Nurses, Royal Victoria Hospital, Montreal.

The study of drugs and their actions is

always fascinating. The rapidity with which new drugs are coming on the market and the rapid extension of information regarding their immediate and delayed effects makes the subject all the more exciting. It must also make the writing of a textbook a monumental task!

This new edition of Faddis and Hayman consists largely of official drugs and those accepted by the Council of the American Pharmaceutical Association. Reference is also made to some new and unofficial remedies, with the permission of the Council on Pharmacy and Chemistry of the American Medical Association. Physicians do prescribe other than Council-accepted drugs and the nurse needs information about them. A complete and up-to-date textbook is essential to any nurse. While drugs change, the basic principles of administration for safety, the need for knowledge of the action of drugs and their toxic effects, and observation of results remain unchanged. Many of the new drugs are very potent. Knowledge and care on the part of the nurse are most necessary.

The book is set up in units. The first deals with drugs in general — how they act, making solutions, and giving medicines. This unit is well illustrated. The other units deal with the drugs affecting the different systems of the body, those used in prevention and treatment, for local effects, and the public and its use of drugs. The last chapter deals with the protection of the public, food and drug acts.

There are good questions at the end of each chapter which help focus the student's attention on important points. It is easy to find the information you want in the book.

Since we in Canada are unlikely to have a Canadian textbook on pharmacology for some time to come, would it be possible for the publisher to include in the edition to be sold in Canada a chapter on the Canadian Food and Drug Act?

British Columbia

The following are staff changes in the British Columbia Division of Public Health Nursing:

Appointments—*Ilaria Bet* (St. Joseph's Hosp., Victoria) to Saanich and South Vancouver Island health unit; *Ruth Clunas* (St. Paul's Hosp., Vancouver) to South Okana-

gan health unit, Kelowna; *Mary Hermann* (V.G.H. and B.A.Sc., University of British Columbia) as part-time nurse, Kitimat; *Mary Kellar* (St.J.H., Victoria) to South Okanagan health unit, Oliver; *Marion Matthews* (Royal Surrey County Hosp., England, and U.B.C. public health nursing course) and *Amy Myers* (St.J.H., Victoria) to Central Vancouver Island health unit, Duncan; *Shirley McKeown* (Royal Jubilee Hosp., Victoria) to South Central health unit, Kamloops; *Evelyn Mitchell* (General Hosp., Regina, Sask.) to Boundary health unit, Langley; *Neda Nichyporuk* (St.J.H., Victoria) to Upper Island health unit, Courtenay; *Helen Pyne* (Winnipeg General Hosp.) to South Okanagan health unit, Keremeos; *Miriam Walmsley* (St.J.H., Victoria) to Central Vancouver Island health unit, Nanaimo; *Kirsten Weber* (Victoria Hosp., Winnipeg) to Simon Fraser health unit, Coquitlam.

Transfers—*Mrs. Ruby Carling* from Skeena health unit, Prince Rupert, to Arrow Lakes district of Selkirk health unit; *Marjorie Craik* from the Division of Tuberculosis Control to Upper Island health unit, Powell River; *B. (MacKinnon) Gardiner* from South Okanagan health unit, Keremeos, to Upper Fraser Valley health unit, Abbots-

ford; *Kathleen Robertson* from Abbotsford to Simon Fraser health unit, Coquitlam.

Resignations — *Margaret Greig* from Central Vancouver Island health unit, Nanaimo; *Louise Hughes* from Boundary health unit, Langley; *Margaret MacLean* from West Kootenay health unit, Greenwood, to join her husband in Germany; *Dorothy Neuman* from Simon Fraser health unit, Coquitlam, and *Margaret Steeves* from Peace River health unit, Dawson Creek — both to be married; *Ann Pearsall* from Upper Island health unit, Powell River; *Irene Stewart* from East Kootenay health unit, Kimberley; *Janet Rodgers.*

* * *

The Royal College of Physicians was constituted in London in 1518. Dr. Linacre, physician to Henry VIII and the projector of the College, was its first president.

News Notes

ALBERTA

HANNA

At the January meeting of District 5, the program committee reported that nursing books had been sent to Ada Sandell in Korea.

RED DEER

At the February meeting of District 6, approximately 50 nurses were present to hear Dr. R. M. Chadwick speak on "Polio." B. Oslund and Mrs. P. Gerke will represent the district at the C.N.A. Biennial Convention in Banff. Discussion centred on the raising of money for a charitable cause and the annual spring dance. A buffet supper of Chinese food was enjoyed by everyone after the business meeting.

The following officers will serve during the coming months: President, Mrs. P. Gerke; vice-president, Mrs. A. Johnson; secretaries, Mmes W. Landon, R. Deus; treasurer, N. MacKenzie.

EDMONTON

Twenty-five members attended the January meeting of District 7 held in the Well Baby Clinic, chairman E. Taylor presiding. Miss Hamilton, chairman of the nominating committee, presented a slate of new officers. Appreciation was expressed to Mrs. Boyd for her humorous contributions to the meetings and by Miss Johnson to Mrs. McPhail for the programs of the past year.

At the February meeting conducted by E. Taylor, 40 members were present. The secretary reported that letters of inquiry

regarding their plans to send staff members to the C.N.A. Biennial Convention had been forwarded to various hospitals. After the business session, Helen Penhale related some of her experiences in South America.

CLARESHOLM

At the February meeting of the Claresholm Chapter held at the home of Mrs. Shearer, 20 members were present. Contributions were collected for the Special Favor Fund in connection with the C.N.A. Biennial Convention. Mr. Charles Gordon showed slides of Korea at the conclusion of the meeting, followed by refreshments served by Mmes Shearer and Schram.

MACLEOD

The following officers were elected by Chinook Chapter to serve during the coming year: President, Mrs. P. Evans; vice-president, Mrs. B. Moore; secretary, Mrs. M. Eckmier; treasurer, Mrs. M. McNab.

WETASKIWIN

Officers elected at the annual meeting of Westaskiwin Chapter are: President, Mrs. M. Fearnehough; vice-presidents, Mmes O. Reimer, Davison; secretary-treasurer, J. Heatley; program convener, F. McWhinney.

Ten dollars was voted to the Polio Fund. A résumé of 1953 activities recalled the assistance of the chapter to the Hospital Board in serving tea at the official opening of the new nurses' home and on Hospital Day; the Red Cross nursing classes given to two groups; a course in polio nursing conducted by L. Kremer; the aid of many members during the polio epidemic; assistance to two Blood Donor clinics; a social evening for husbands and friends in November.

CALGARY

Holy Cross Hospital

The In-Service Educational Program for the graduate staff continued during February with a lecture by Dr. H. V. Morgan on Complications and Nursing Care following Cholecystectomy and a new film of the Alberta Red Cross Hospital entitled "They Dance Again."

The Grey Nuns and instructors entertained the preliminary students and their Big Sisters at tea. The latter had received their caps at a capping ceremony some time previously when Mrs. Frank Fish, noted Calgary speaker, addressed the class of 36 "new caps" and others in attendance.

BRITISH COLUMBIA

CHILLIWACK

Mrs. A. Edmeston was elected president of Chilliwack Chapter at the annual meeting, together with vice-president, Mrs. F. Barwell; secretary, M. Macartney; treasurer, Mrs. H. Bersea; committee members, Misses K. Crowley, M. Zink, Mmes G. Sache, H. Brown, M. Firby, B. McKay, P. Penner,

E. Roberts, T. Heaton. Mrs. E. Taylor is the representative to *The Canadian Nurse.*

Among the many projects of a very busy year were the following: The support of an adopted child through the Save the Children Fund; special nursing services provided and funds raised by a tea and rummage sale; the award of the Enid Chadsey Bursary to Christine Neilson in training at Vancouver General Hospital; donations to the Polio Fund and the Community Chest as well as the School for Retarded and Handicapped Children, European Flood Relief, Bread for Greece, and the New Delhi Surgical Fund; assistance to the miniature chest T.B. x-ray clinic, CARS, Film and Citizenship councils, Upper Fraser Valley Society for Retarded and Handicapped Children, and the senior hospital auxiliary; home nursing classes conducted by Mrs. Barwell in conjunction with the Red Cross.

During the year the chapter visited the Crease Clinic and attended church in uniform on Florence Nightingale Sunday. Misses Crowley and Macartney represented the chapter at the annual provincial convention in Vancouver. The chapter has decided to furnish a ward in the proposed new wing of the General Hospital.

Prince George

Dr. Maxwell Evans, director of the Cancer Institute, spoke to a large group of nurses recently on the work of the institute and research, symptoms and treatment of cancer, including the use of the Cobalt unit. Slides picturing the disease, treatment, and results were exhibited. Prince George is one of the consultive points where past patients may be checked.

At the annual meeting of Fort George Chapter, Shirley Bradford retained the presidency and other officers elected were: Vice-president, Mrs. M. Maxwell; secretary, Mrs. Z. Leyland; treasurer, Mrs. I. Ford.

This chapter will join those of Quesnel and Williams Lake in Cariboo District since the proximity of the newly formed Burns Lake Chapter to Smithers makes their being together in the Central Interior District advantageous.

The annual bursary was awarded to Patricia Ganton, now in training at Vancouver General Hospital. Among other activities during 1953, 10 members attended a district meeting at Burns Lake; C.N.A. Structure Study was reviewed and a panel discussion on "Our Senior Citizens" held; Mr. Neil Carlson of the National Film Board Council explained the Board's functions and six films were shown throughout the year.

Trail

President A. Baker conducted the regular monthly meeting of Trail Chapter in February. The sum of $287.50 was netted from the dance convened by Mrs. Morris to whom a vote of thanks was made. The revised district by-laws have been forwarded to the

Legislation Committee for approval. A rummage sale will be held on June 25. At the conclusion of the business meeting, Flora McLean spoke on her trip to the I.C.N. Congress in Brazil, illustrated with films.

VICTORIA

Royal Jubilee Hospital

The following are members of the current post-graduate class taking the course in operating room technique and administration: Mrs. A. Beier on leave from Nanaimo Hospital; B. J. Cuthbert, D. Smith, on leave from R.J.H.; P. Hreherchek, recently at Shaughnessy Hospital, Vancouver, and L. M. Nordin, on leave from same hospital; S. J. Peel, on leave from Calgary General Hospital; N/S D. Taylor on leave from *H.M.C.S. Naden.*

MANITOBA

BRANDON

A recent meeting of the Association of Graduate Nurses took the form of a dinner in honor of senior members Mmes S. Pierce, R. Darrach, Misses C. Macleod, M. Gemmell. Under the chairmanship of the president, Mrs. E. Hannah, 70 nurses attended. Mrs. Pierce was the recipient of an orchid and greetings as it was also her birthday. J. Higgens, accompanied by Mrs. J. Fargey, led the sing-song. Following the reports of officers and committee conveners a vote of thanks was extended to Mmes G. Johnston, A. Disher, and 16 ladies of the Order of the Royal Purple for their successful catering for the dinner.

Mmes P. Leitch and S. Lewis made "In Memoriam" addresses in tribute to the late Ellen Birtles and Mrs. W. H. Shillinglaw. Among many honors, Miss Birtles received an O.B.E. in 1935. She died in 1943. Mrs. Lewis recounted many instances of the unselfish devotion to nursing and benevolent work performed by Mrs. Shillinglaw, who had also been matron of Brandon General.

After formal presentation each guest of honor received a corsage. Reminiscences of earlier nursing and comparisons of then and now were general.

The association held another very successful annual tea at the nurses' residence of the General Hospital recently, under the convenership of P. Long, L. Millions, and Mrs. D. Hatch, assisted by their committee. Mrs. E. Hannah and M. Jackson received the guests. The tea table was beautifully arranged by the student body under President M. Chalmers. Sharing the tea honors were: Mmes F. Fjeldsted, H. McIntyre, J. F. E. Purdie, and J. A. Findlay, with the assistance of many other members. Mmes W. Anderson, R. Mathie, R. Catley, L. G. Chown, and Miss C. Stewart were in charge of the home-cooking and candy tables.

General Hospital

The capping ceremony of the 1956 B class took place on February 1 in St. Mary's

Anglican Church. Thirteen student nurses received their caps from M. Jackson, director of nursing, and, with the Big Sisters, repeated the Florence Nightingale Pledge. The presentation of the students was made by the nursing arts instructor, J. Higgens.

St. Boniface

One hundred and forty-eight members were present at the annual dinner meeting of the St. Boniface Hospital Alumnae Association when graduating classes were represented from 1913 to 1953. The annual reports from the executive and committees revealed a busy and successful year. In future, the alumnae meetings shall be held as follows:

The annual meeting on second Wednesday of January; general meetings on second Wednesday of January, March, and October at 8:00 p.m.; further general meetings shall be called at discretion of executive. Members are also asked to remember: Spring tea in April; annual dance in May in honor of the graduating class; Fall dance in November.

The scholarship committee reported the investment of $2,000 in government bonds. Sr. Dorais, superior and administrator of the hospital, presented a progress report of the new hospital which it is hoped will be completed by the end of this year.

The following officers will serve during the coming year: Honorary president, Sr. D. Clermont; president, M. Gibson; vice-presidents, Mmes R. H. McNaughton, E. Dwyer; secretaries, Mmes H. Lemoine, M. Mahaffy; treasurer, B. Deshaye; archivist, Mrs. P. Wlock. Also serving in various capacities: Misses L. Dick, S. Lawson, T. Greville, Grice, B. Smith, L. Deconnick, F. Buhr, M. Gabrielle, K. McCallum, P. Hannon, C. Bourgeault, K. Doyle, Mmes F. Dumas, S. Kobrinsky, M. Fraser, S. Dmyterko, D. Curran, J. Gauthier.

Winnipeg

General Hospital

Christine Carson, representative of the Canadian Federation of Teachers at the Coronation, was guest speaker at the February meeting of the alumnae association. Plans were made for the annual spring tea and it was noted that the graduation of the 1954 class is on May 17, the dinner being given by the alumnae for the graduates on May 21. Margaret Cameron, newly appointed director of nursing, was formally introduced to the members.

Misericordia General Hospital

Most Rev. Philip F. Pocock, Roman Catholic archbishop, turned the first sod on the construction of a $2,500,000 extension to the hospital at a brief ceremony attended by representatives of the city, province, and members of the staff and board of directors. The new wing will form the main part of the extension and, when ready for occupancy, the original one built in 1899 will be torn down and replaced. All work is ex-

pected to be done by the end of 1955. The north wing will be turned into a nurses' residence with auditorium and swimming pool.

The alumnae association tea, convened by Mmes E. McLaren, B. Stuart, R. Natsuk, Cutts, Genay, Ireland and Miss A. Gunn, was held in the Beaver Hall of the Hudson's Bay Company. President M. Dyck and Mrs. R. Smith, social convener, received the guests and presidents of other hospital alumnaes and wives of the medical staff graciously consented to pour. Proceeds will be used for the scholarship fund.

NEW BRUNSWICK

MONCTON

At a recent meeting of the Moncton Chapter, constitution and by-laws were presented and approved with slight changes and a subscription to *The Canadian Nurse* was sent to a foreign nurse.

Nurses' Hospital Aid

Mrs. J. Innes was in the chair at a regular meeting held at the new Moncton Hospital when routine business was transacted. A demonstration of the needle cleaner, which the Aid had donated to the hospital, was given by Mrs. M. Wilbur.

SAINT JOHN

Louise Peters, assistant director of nurses at the General Hospital, was elected president of the Saint John Chapter at the annual meeting. J. Stephenson, acting president, was in the chair. A moment of silence was observed in tribute to the memory of the late Miss E. Mitchell, honorary president. The membership totalled 395 and the chapter renewed its membership in the Local Council of Women, appointing M. Murdock to carry the chapter's report to the Council's annual meeting. The chief aim in 1953 was the maintenance of the nurses' registry. Educational programs were featured at all regular meetings. Members were urged to attend the C.N.A. Biennial Convention in Banff.

Associated in office with Miss Peters are: Past president, F. Saunders; vice-presidents, W. Hoosier, H. McCallum; secretaries, J. Smith, J. Thorne; treasurer. K. Christiansen. Others serving are: M. Harvey, D. Byers, G. Black, A. Peters, M. Lewis, Mrs. B. Murchison. The representative to *The Canadian Nurse* is M. Craig.

General Hospital

Mildred Moore was elected president of the alumnae association at the annual meeting chaired by the retiring president, B. Selfridge. Others elected are: Honorary president, Mrs. J. Vaugh; vice-presidents, Mmes R. Corbett, R. Nason; secretaries, Mrs. G. Somerville, A. Schofield; treasurers, Mmes S. Rankin, W. McKinnon; and in various capacities, W. Hoosier, P. Harrity, L. Floyd, Mmes M. O'Neal, R. Dunlop, E. Mooney.

Committee reports were gratifying and

it was planned that the information gathered on the history of nursing would be put into manuscript form at once.

Lancaster D.V.A. Hospital

Nursing Sister Mary M. Phillips is taking a six-month course at the Neurological Institute, Montreal.

St. Joseph's Hospital

Sr. Stella Maris, supervisor of the obstetrical dept., attended the course on supervision given in Halifax. Sr. Marie de Lourdes, operating room supervisor, is taking a post-graduate course in O.R. technique and management at Skidmore College, New York City, while A. Corkery and M. Horgan are at St. Michael's Hospital, Toronto, for similar study. J. Kinsella is now on the staff of St. J.H.

ONTARIO

District 4

Welland

A successful year of activities came to a close at a recent dinner meeting of Niagara Chapter, attended by about 120. The Rev. Dr. Rawson, guest speaker, named four principles — friendship, family, faith, and achievement — in his talk on what he would like from life.

The membership, increased by 171 over that of last year, now stands at 603. Plans for the repetition of the essay contest on "What the R.N.A.O. Can Mean to Me" for senior student nurses, and composition of a welcoming letter to all new nursing personnel encouraging membership in the R.N.A.O. are under way.

St. Catharines

General Hospital

For some years the alumnae of Mack Training School for Nurses has recognized the definite need for a home for graduates of the school who have retired and on a limited income find it difficult to maintain a comfortable standard of living. A sum of money was set aside in 1949 with the hope of establishing a fund to be used for the purchase of a home. In 1952 the late Nora Nold organized a committee and worked diligently to acquaint all graduates of the school with this project. Her plans were just beginning to materialize when her death occurred last September. The association is looking to its members and friends to help the dream of "The Mack Home" to be realized.

For further information regarding this project and contributions write *Mrs. H. C. Wallace, 63 Yates St.* in St. Catharines.

District 5

Toronto

W. Hendrikz, retiring chairman, in her review of the accomplishments of last year at the annual meeting of District 5, observed that the donation to the University School of

Obstetrics and Nursing, Tarija, Bolivia, had been made.

A second chapter was formed in the Newmarket area in 1953. The membership has reached a maximum of 3,458, an increase of 782 over 1952. Bursaries were granted to 10 student nurses during the year. Of 29,349 calls, the Central Registry was able to fill 22,819. The Study Guides for students and young graduates are now available in medicine, surgery, obstetrics, and pediatrics.

Mrs. W. R. Walton, past president of Canadian Association of Consumers, as guest speaker spoke on "Every Woman's Business."

Officers elected are: Chairman, J. Wilson; Vice-chairmen, R. Watson, Mrs. R. Couse; secretary-treasurer, Mrs. M. Chisholm; councillors, E. Davidson, A. Pennell, J. Secor, A. M. Schiach. Chairmen of Chapters 1 & 2, J. Hefferman, Mrs. V. McPherson.

Western Hospital

The February meeting of the alumnae association was held with the president, K. Ellis, in the chair. The executive for 1954 is as follows: Past president, B. Miles; president, K. Ellis; secretaries, M. Mackenzie, Mrs. J. Gibson; treasurer, M. Steed. Mr. A. Brown of the Board of Education, guest speaker, chose the interesting subject, "Characters I have Known."

The members of the alumnae entertained the graduation class of 1954 at dinner. Orchestral music was provided throughout the evening and Mr. A. J. Swanson, hospital superintendent, proposed a toast to the 80 nurses who graduate this year. Bridge and dancing brought the evening to a close.

District 7

Kingston

Sr. Mantle, the retiring chairman, presided at the annual meeting of District 7. J. Godard, instructor of nursing at the General Hospital, is the new chairman and A. Baker, nursing instructor at Ongwanada Sanatorium, secretary-treasurer. A banquet attended by 140 nurses followed and the address of the guest speaker, Prof. Edinborough of Queen's University, on "The Pleasure of Reading" was most interesting.

District 10

Port Arthur

The annual district meeting took the form of an all-day convention in February, the first of its kind at the Lakehead. The Lakehead, plus the outlying chapters of Kenora, Sioux Lookout, and Dryden, was well represented. The president, Sr. Patricia, opened the morning session when reports were heard from the public health nursing group, followed by a film.

In the afternoon greetings were received from the Thunder Bay Medical Association and the Lakehead Hospital Council. Reports were heard from the private nursing, indus-

trial nursing, and *Canadian Nurse* committees. D. Shaw, who participated in a course in New York on Team Concept of Nursing, commented on this subject for the institutional nursing committee. The personnel manager of the Marathon Paper Co., Mr. Kenneth Eoll, was guest speaker at this session. His subject was "Human Relations."

The evening gathering took the form of a dinner banquet at McKellar Hospital, Fort William, with Alderman (Mrs.) Eunice Wishart as guest speaker. Her subject — "Women are Here to Stay" — was well received.

The following compose the new executive: President, K. Feisel; past president, Sr. Patricia; vice-president, M. Pringle; secretary-treasurer, M. O'Rourke.

PRINCE EDWARD ISLAND

CHARLOTTETOWN

D. Cox and B. Smith, public health nurses, with the Provincial Dept. of Health and Welfare, are taking a three-month course in mental health and L. Gillis and R. Preece, the certificate course in public health nursing at Dalhousie University, Halifax. The latter will return to join the staff of the Provincial Dept. of Health and Welfare.

Charlottetown Hospital

Five nurses have been released to take post-graduate courses in various fields of nursing: R. Griffin in O.R. technique, Winnipeg General Hospital; E. MacEachern, obstetrical nursing, Boston Lying-In Hospital; K. T. Campbell, obstetrical nursing, Royal Victoria Hospital, Montreal; Sr. M. Gabriel, pediatric nursing, Hospital for Sick Children, Toronto; and Sr. M. Patricia, surgical nursing, Toronto University.

P.E.I. Hospital

The president, Mrs. W. Shaw, conducted a recent meeting of the alumnae association. Florence MacLean introduced the guest speaker, Dr. George Fisher, director of veterinary services, Dept. of Agriculture, who spoke on the United Nations, stressing the need for leadership of youth groups in local communities.

QUEBEC

MONTREAL

Royal Victoria Hospital

This year marks the Diamond Jubilee of the hospital. The Spring class of preliminary students was welcomed to the school in February.

Dr. T. J. Boag of the Allan Memorial Institute was the guest speaker at an alumnae meeting. It was announced that the alumnae dinner will be held on April 29 at the Ritz Carlton Hotel.

M. McKenney is stationed at *H.M.C.S. Naden*, Esquimalt, B.C., while M. Williams is at *H.M.C.S. Stadacona*, Halifax. E. Burgoyne is in charge of a urological ward at the New York Medical Centre. Also at the Centre are: G. MacKay, E. (Beall) MacKinnon, and J. Timmins. E. O'Neill, who is engaged in private nursing in New York, was a recent visitor. Other visitors were: F. (Allen) Ross, president of the Halifax chapter of the alumnae; M. Coleman and C. MacCallum who are on the staff of McKellar General Hospital, Fort William.

QUEBEC CITY

Jeffery Hale's Hospital

Twenty members attended the annual meeting of the alumnae association conducted by Mrs. Teakle, the president. Various committee reports were read and the following officers elected: President, M. Jones; vice-presidents, Mmes J. Myers, A. Seale; secretary, Mrs. D. Eglinton; treasurer, Mrs. V. Denison. Others serving are: Mmes Teakle, Kennedy, Nattress, Beattie, Baptist, Simons, West, Green, Pugh, Firth, Cormack, Young, Treggett, Misses Walsh, Currie, Weary, MacDonald, Ford. The representative to *The Canadian Nurse* is M. Dawson.

Mrs. C. Young has received the Coronation Medal and Citation from Ottawa.

SASKATCHEWAN

REGINA

Grey Nuns' Hospital

The nurses' residence was the setting for

the capping ceremony in which 51 students, members of the September 1953 class, participated. Two hundred guests witnessed the impressive ceremony as the students filed into the room to the processional march played by a senior student, A. Schmalz. Mrs. R. MacCormach, nursing arts instructor, welcomed the guests and congratulated the students about to receive their caps, carried by two little cap bearers, twin sisters. The candlelight ceremony, followed by the student nurses' pledge, was led by J. Cousins, president of the Student Council assisted by A. Barker. The group was then favored with a violin solo by M. Jamieson.

Father J. W. Dyer, Dean of Studies at Campion College, was guest speaker and Father P. Kinlin, chaplain of the hospital, offered congratulations to the class. D. Johnson and E. Carriere presented musical selections. Following the recessional march, the students with their guests made a tour of the hospital. A reception followed.

SASKATOON

City Hospital

Mrs. A. MacMillan was elected president of the alumnae association when a brief summary of the year's activities was given. Highlights included: Joint meeting with St. Paul's alumnae; card party for the graduating class; presentation of general proficiency medal at graduation; Halloween dance and children's Christmas party.

The following officers will serve with Mrs. MacMillan during the coming months: Past president, Mrs. H. Wilson; vice-president, Mmes M. Barry, H. Sugarman; secretary, Mrs. J. McNelles; treasurer, Mrs. J. Reder. Committee conveners include: D. Knuckey, F. Bassingthwaighte, Mmes J. Levers, D. Parkinson, J. Blacklock, R. Newby.

Seventy City Hospital graduates signed the register at the Alumnae Membership Tea held in February. The president, Mrs. MacMillan, and the past president, Mrs. Wilson, welcomed the guests. Mrs. Parkinson, assisted by E. Blacklock, conducted group singing. The coffee table was presided over by Mmes L. McAskill and Wilson.

An Educational Tea was served to welcome the new students who arrived in January. Greeting the guests were: R. Miller, J. Brown, and J. Tennant. Presiding at the tea table were: D. Riesz, M. Jira, E. Olzewski, R. Klymyshyn, and C. Rosinski.

New graduates on the staff include: L. Anear, J. Brown, M. Cairnie, H. Cameron, M. Carlson, B. Empey, P. Epp, M. Gregorchuk, C. O'Mara, G. Peterson, E. M. Stuart, Mmes H. (McAdam) Parsons, E. Reimer, M. Uhryn.

St. Paul's Hospital

A series of lectures on plastic surgery and gynecology by Drs. H. Dale and R. H. MacPherson is part of an in-service educational program. February saw the capping of 37 Freshman A class and the welcoming of 25 new Freshman B.

Positions Vacant

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Director of Nursing & Principal of School of Nursing. 200-bed hospital with Training School & staffed with Associate Directors of Nursing Service & Nursing Education. Construction of hospital on new site expected to commence this yr. Apply, stating training, qualifications & experience, R. Ross MacKay, Administrator, Greater Niagara General Hospital, Niagara Falls, Ont.

Nursing Arts Instructor. New 188-bed hospital; 60-75 students. 1 yr. university course in Teaching required. Personnel policies. 2 wks. sick leave; 8 statutory holidays; 4 wks. vacation. Particulars of salary on request. Apply Director of Nursing, General Hospital, Stratford, Ont.

Nursing Instructor. New 330-bed hospital opening in May. Excellent salary & personnel policies. For further information apply Director of Nursing, St. Thomas-Elgin General Hospital, St. Thomas, Ont.

Instructors for: Science Teaching followed by Clinical Ward Teaching; Clinical Ward Teaching & lectures in Medical Nursing. Commencing salary: $250 (additional for experience). Current R.N.A.B.C. contract in effect. 65 students; one class per yr. For information about position & community apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Science Instructor & Surgical Clinical Instructor. State salary expected. 195-bed hospital with established affiliation in Psychiatry & Tuberculosis. 70 students. For further information apply Miss M. E. Jackson, Director of Nursing, General Hospital, Brandon, Manitoba.

Operating Room Supervisor (experienced) with post-graduate course. Modern O.R. (3 rooms). New hospital with most up-to-date equipment. Salary open. Apply Supt., City Hospital, Sydney, N.S.

Graduate Nurses for General Duty in Obstetrics & Surgery. Modern 110-bed hospital. Commencing salary: $135 per mo. after deductions for board & room. Comfortable nurses' home. Apply Supt. of Nurses, Western Memorial Hospital, Corner Brook, Newfoundland.

General Duty Nurses for attractive 60-bed hospital in Southern Ontario town. Basic salary: $200 per mo. with increments each 6 mos. to $215. Evening & night shifts additional $15 per mo. Benefits: Free laundry, cumulative sick time, 3 wks. vacation, 7 statutory holidays. Apply Director of Nurses, Alexandra Hospital, Ingersoll, Ontario.

GENERAL STAFF NURSES

for

200-bed hospital

Pleasant city of 33,000. Two colleges.

Good salary and personnel policy.

For further information apply to:

DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO.

Registered Nurse for General Staff Duty. 31-bed hospital. Beginning gross salary: $215 per mo. with full maintenance. Recognition for yrs. of experience. $5.00 increments each 6 mos. 8-hr. day. 1 mo. vacation with pay after 1 yr. 2 wks. sick leave with pay. For further information apply Supt. of Nurses, Union Hospital, Unity, Sask.

General Duty Nurses for 430-bed hospital. Salary: $230-260. Credit for past experience. Annual increments. 40-hr. wk. Statutory holidays; 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty Nurses for 50-bed hospital. New nurses' home in modern town of 2,500. Excellent working conditions. Minimum net salary: $170 with $10 increase for each yr. of experience up to maximum of $210 net. Additional increments for special duties & training. Apply Mrs. E. White, Matron, Municipal Hospital, Hanna, Alta.

General Duty Nurses. 650-bed Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

Supt. for 125-bed hospital with small Training School. Apply Sec., Board of Trustees. Prince County Hospital, Summerside, P.E.I.

Supt. of Nurses & O.R. Supervisor for General Hospital, Dauphin, Man. 86-bed hospital with Nurses' Training School. Community of 6,500. Excellent living conditions. Supt. of Nurses must be good organizer & disciplinarian. Salary open for both positions. For further information apply A. J. Schmiedl, Sec.-Mgr.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Director of Nurse Education. Training School of 36 students. 44-hr. wk. Full maintenance. Apply, stating experience & salary expected, M. Amy White, Supt., General & Marine Hospital, Collingwood, Ont.

Instructor in Science & Surgical Nursing for new school taking in one class yearly. Responsible for teaching Chemistry, & Anatomy & Physiology in 1st term & the Surgical portion of an integrated course in Medical-Surgical Nursing in 2nd term. Splendid opportunity to help develop new school being established on sound educational lines. For further information apply Director, School of Nursing, Metropolitan General Hospital, Windsor, Ont.

Instructors (qualified): **Nursing Arts (1) & Clinical (1)** by Aug. 1 for 200-bed hospital. 65 students; one class per yr. enters in Sept. Allowance made for degree with experience. For further information apply Director of Nurses, General Hospital, Guelph, Ont.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $231.00 as minimum and $268.50 as maximum, plus shift differential for evening and night duty.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Nursing Arts Instructor & **Clinical Instructors in Medicine & Surgery.** Apply Director of Nurses, Misericordia Hospital, Edmonton, Alta.

Science Instructor for June or Sept. Complete maintenance in comfortable suite. 120-bed hospital — 35 students. New 150-bed hospital under construction. Apply, stating experience & salary expected, Director of Nurses, Jeffery Hale's Hospital, Quebec City. Quebec.

Clinical Instructor for Surgical Nursing (1). School of Nursing with 90 students. Duties to commence July 1. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Clinical Supervisors & Instructors: Surgical (2) & Medical (2). Also **General Staff Nurses.** Personnel policies based on R.N.A.O. recommendations. For full details apply Director of Nursing, General Hospital, Port Arthur, Ont.

Laboratory Technician (1), Registered Nurses (5) — one with O.R. experience. Also **Grace Maternity Graduates.** Three 8-hr. shifts, alternating weekly. Good personnel policies covering vacation, hospitalization & sick time. Apply Supt., Queens General Hospital, Liverpool, N.S.

Laboratory Technician for 67-bed General Hospital. Salary open. Apply Supt., General Hospital, Portage la Prairie, Manitoba.

Public Health Nurse for Health Unit for generalized program. Proximity to Toronto permits urban living conditions to be combined with rural-urban work. Excellent transportation arrangements, group insurance & other attractive working conditions Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

If you are coming to Britain to nurse, you will be welcome at 324-bed Sully Hospital. Sully, Glamorgan, South Wales. Modern hospital on the sea. Experience available in Medical & Surgical Nursing of all Chest Diseases in adults & children. Post-graduate course for British Tuberculosis Ass'n Certificate & instruction by medical staff & tutor. Comfortable, modern nurses' home with recreational facilities. For further information write H. M. Foreman, M.B.E., M.B., Physician Supt.

If you are coming to Britain to nurse, you will be welcome at 240-bed Glan Ely Hospital (Pulmonary & Non-Pulmonary), Fairwater, Cardiff, South Wales. **Female Staff Nurses (S.R.N.)** — excellent experience available in bone & joint surgery & thoracic surgery. British Tuberculosis Ass'n Certificate may be obtained after 12 mos. service. **Female Student Nurses** for B.T.A. Cert. **Pupil Asst. Nurses** for Training School inaugurated with two local hospitals. All posts resident or non-resident. For further particulars write Matron.

WANTED

CLINICAL INSTRUCTOR FOR PEDIATRICS

for

War Memorial Children's Hospital

Capacity: 140-150 beds.

Post-graduate course preferred.

Good salary and Personnel Policies.

Apply:

Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses: Starting salaries as indicated — **Asst. Nursing Supervisor,** $315; **Instrument Nurse,** $292; **General Duty Nurse,** $270. 500-bed Teaching Hospital, School of Nursing, Intern & Resident programs. Paid vacation, sick leave & holidays. 40-hr. wk. 6-mo. increases. 5% afternoon & night shift premium. Apply Personnel Office, Hurley Hospital, Flint, Michigan.

Registered Nurses, Grace Hospital Graduates & Certified Nursing Assistants. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

Registered Nurses for General Duty (2). 70-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Salary: $165 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. 1 mo. annual vacation with pay plus statutory holidays. 8-hr. day, 44-hr. wk. Apply Supt., Municipal Hospital, Brooks, Alta.

Registered Nurses for General Duty in 600-bed hospital for Tuberculosis. Initial gross salary: $185 per mo. 8-hr. duty, 44-hr. wk. Board & room available. Apply Director of Nursing, Beck Memorial Sanatorium, London, Ont.

Registered General Duty Nurses for new 175-bed hospital. Excellent working conditions & personnel policies. Apply Director of Nursing, South Waterloo Memorial Hospital, Inc., Galt, Ontario.

Registered Nurses for floor duty in 50-bed modern General Hospital. Apply District Memorial Hospital, Leamington, Ont.

Registered Nurses (2) as soon as possible for 50-bed hospital. Salary: $210 per mo. gross plus $5.00 increase per 6 mos. for 2 yrs. 48-hr. wk. — straight shifts. 1 mo. holiday with pay after 1 yr. 3 wks. sick time. Pop. of Rosetown — 2,500, English-speaking; on C.N.R. line, Saskatoon-Calgary. Apply Matron, Union Hospital, Rosetown, Sask.

Registered Nurses for the Public Health Nursing field by the Saskatchewan Department of Public Health. Provision is made for in-service training & for financial assistance to complete university post-graduate training in Public Health Nursing. For application forms & further information apply Public Service Commission, Legislative Bldgs., Regina, Sask.

General Duty Registered Nurses for modern industrial hospital. Working knowledge of French language necessary. Good salary. 40-hr. wk. Blue Cross, pension & group life insurance plans available. Excellent living quarters. Good recreational facilities. Apply Employment Mgr., Canadian Johns-Manville Co. Ltd., Asbestos, Que.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONT.

invites applications for the following positions:

• ***Operating Room Supervisor***—Post-graduate course in Operating Room Technique with at least 3 yrs. experience or certificate in Teaching & Supervision (Operating Room Technique). New 6-theatre dept. with new modern equipment, opened in Oct. 1953. Position available *May 1.* Salary commensurate with qualifications & experience.

• ***Nursing Arts Instructor***—For *July or Aug. 1.* 435-bed hospital with new modern fully equipped wing of 162 beds, opened in Fall of 1953. 75 Student Nurses currently enrolled in School. Salary commensurate with qualifications & experience.

• ***Clinical Instructors***—For 55-bed Pediatric Unit & 43-bed Medical Unit in new modern Hospital Wing. Salary commensurate with qualifications.

Apply Superintendent.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurses (3) at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alberta.

Central Alberta Sanatorium, Calgary, Alta., offers to **Graduate Nurses** a 6-mo. post-graduate course in Tuberculosis. Maintenance & salary as for General Staff Nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Clinical Teacher with Pediatric experience. Post-graduate course preferred but not necessary. Apply Director of Nursing, Children's Memorial Hospital, Montreal 25, Que.

Public Health Nurses (qualified) for City of Oshawa. Two vacancies. Generalized program in urban area. Minimum salary: $2,700; allowance for experience. Transportation provided. 5-day wk. 4 wks. vacation. Sick leave with pay. Pension plan. Hospital insurance. P.S.I. available on participating basis. Apply Board of Health, Oshawa, Ont.

Public Health Nurses for generalized program in rural-suburban Health Unit near Toronto. Excellent salaries. Pension plan. For full details apply Supervisor, Peel County Health Unit, Court House, Brampton, Ont.

Registered Nurses for General Duty for small General Hospital. Additional staff required to institute 44-hr. wk. Salary: $150 per mo. with full maintenance. 8-hr. duty; rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross. 10 days sick leave per yr. 6 statutory holidays. 28 days vacation. $30 bonus for working during July, Aug. & Sept. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses (2) for 30-bed hospital. Salary: $220 per mo. less $40 for full maintenance. 4 wks. yearly vacation. 18 days sick leave. Apply Community Hospital, Grand Forks, British Columbia.

Director of Nurses by May 15 for Children's Hospital, Winnipeg, Man. 120 beds plus large O.P.D., expanding in new building to 250 beds. School of Nursing (60 students) may be reorganized to conduct affiliate course in Pediatrics plus post-graduate training in Pediatrics. Qualifications: Training & experience in Nursing Administration or Education; experience in Pediatric Nursing. Salary open. Apply Supt.

POSITIONS VACANT

Matron for 34-bed hospital by June 1. Starting salary: $190 per mo. plus full maintenance. Partial Blue Cross payments. 3 wks. vacation with pay 1st yr. employment; 4 wks. after 2nd yr. Regular sick leave plus all statutory holidays. Apply Supt. of Nurses, Altona Hospital, Altona, Man.

Nursing Arts Instructor. School of Nursing: 55 students. 125-bed hospital. For further information apply Director of Nursing, Children's Hospital, Winnipeg, Man.

Registered General Duty Nurses for all services. 550-bed hospital. Salary: $230 per mo. Reasonable living accommodations available on campus. 8-hr. day; 40-hr. wk. — rotating shifts. Annual sick & holiday leave. Social Security. Retirement plan. Apply Director of Nursing Service, Medical College of Virginia Hospital, Richmond, Virginia.

Public Health Nurse for city of Peterborough. Basic salary: $2,700 per yr. (inexperienced). Annual increment, $150. Transportation allowance or vehicle provided. 5-day wk. Pension plan. Annual vacation: 1 mo. with additional time at Christmas & Easter. Apply Dr. J. P. Wells, Medical Officer of Health, City Hall, Peterborough, Ont.

Staff Nurses. 40-hr. wk. Differential — 3-11; 11-7. Liberal personnel policies. Apply Director, Dept. of Nursing, New Grace Hospital, 18700 Meyers Rd., Detroit 35, Michigan.

Supt. of Nurses with Operating Room experience for 35-bed hospital. Apply, stating experience, salary expected, references, etc., to Sec., Swan River Hospital, Swan River, Man.

Supt. immediately for modern 125-bed hospital opened last October. Apply, stating qualifications & experience, Sec., Charlotte County Hospital, St. Stephen, N.B.

Instructor in Nursing Arts. Clinical Instructor in Medicine. Clinical Instructor in Surgery. For School of Nursing by Aug. 1. 177-bed hospital; affiliation arranged in Tuberculosis & Psychiatric Nursing. Maximum of 60 students. One class per yr. Complete maintenance available. Excellent personnel policies. For further particulars apply Miss E. A. Bietsch, Director of Nursing, General Hospital, Medicine Hat, Alberta.

Operating Room Supervisor for attractive new 60-bed hospital in Southern Ontario town. Salary: $250 per mo. Working conditions exceptionally pleasant & staff cooperation of high order. Apply Director of Nurses, Alexandra Hospital, Ingersoll, Ontario.

Senior Instructor to teach Nursing Arts & direct teaching program. Vacancy Aug. 1. Psychiatric Nursing experience preferred. Salary: $266-321 per mo. Also **Graduate Nurses** with Psychiatric training—Salary: $216-256 per mo.; without Psychiatric training—$211-251. 1,450-bed active treatment hospital conducting accredited school of training. 44-hr. wk. Residence with board, if desired: $30 per mo. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

THE PROVINCE OF MANITOBA

requires an

INSTRUCTRESS of NURSING

for the Hospital for Mental Diseases, at Selkirk, Manitoba.

Qualifications: Registered Nurse preferably with Mental Nursing Certificate, but this latter is not essential.

Duties: To carry out program of teaching of pupil nurses that they may qualify as licensed practical nurses and as psychiatric nurses.

The above position offers full Civil Service benefits — liberal sick leave, four weeks' vacation with pay annually, and pension privileges.

Apply, stating qualifications, experience and salary required, to:

MANITOBA CIVIL SERVICE COMMISSION
247 Legislative Building,
Winnipeg, Manitoba.